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I hereby authorize the release of my records and x-rays or copies of such and request that they are transferred to:



Dr. Philip N. Heinecke, DDS, PA

Phone: (352)-796-0917

103 Bell Avenue Brooksville, FL 34601

Brooksville Fax: (352)-796-0937

Brooksville Email: Brooksville@drheinecke.com

7135 Mariner Blvd Spring Hill, FL 34609

Spring Hill Fax: (352)-515-5761

Spring Hill Email: hmtooth@gmail.com

Print Name of Patient

Date of Birth

Signature

Date

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