3585 124th Ave. N.W.
Coon Rapids, MN 55433
Ph: 763-767-1524 Fax: 763-767-1528

Authorization for Release of Dental Records and X-ray

Patient Name(s):_____, _____

_____

Patient(s) Date of Birth: _____, _____, _____

I, _____, request that you release copies of:

( ) most recent dates of cleaning, exam, x-rays and brief dental history
( ) films enclosed if bitewings are within one year, panoramic within five years
( ) all records

Send records to:

Full Dr. Name _____

Street Address _____

City, Zip Code _____

Practice Telephone Number _____

Practice E-mail Address _____

Signature: _____
Parent or guardian signature

Reason For Leaving Our Office _____

_____

Please note: These copies may be electronic or print submissions