Authorization for Release of Dental Records

Dalseth Family and Cosmetic Dentistry

Today's Date: _____

I authorize the release of my dental and medical information to Dalseth Family and Cosmetic Dentistry (bitewings within 18 months, panoramic and/or full mouth series within 5 years).

Patient Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Signature: _____

Dental Clinic

Dental Clinic: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Dalseth Family and Cosmetic Dentistry

14505 Glazier Avenue

Apple Valley, MN 55124

Authorization for Release of Dental Records

Dalseth Family and Cosmetic Dentistry

Today's Date: _____

Patient Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Signature: _____

Authorization

I authorize Dalseth Family and Cosmetic Dentistry to release my dental and medical information (bitewings within 18 months, panoramic and/or full mouth series within 5 years) to:

Office/Doctor's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

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Apple Valley, MN 55124