Authorization for Release of Dental Records and X-rays

I, (print patient or guardian name) _____,hereby

Authorize the doctors and staff of _____
(name of previous clinic)

To release records or knowledge concerning my dental health to:

Hale Family Dental
5201 Bloomington Ave
Minneapolis, MN 55417
Email: info@halefamilydental.com
Phone: 612-721-6233
Fax: 612-721-5723

I specifically request that you release copies of all x-rays and all treatment notes.

Signed (patient or guardian name) _____

Printed name (patient or guardian name)_____

Date:_____