



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](mailto: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: \_\_\_\_\_