edina dental care
COMPREHENSIVE AND AESTHETIC DENTAL CARE

Authorization for the Release of Dental Records

I hereby authorize

_____

dental office

to release the information in the dental record belonging to

_____

patient name DOB

Please send records and dental images to:

Edina Dental Care
Email: info@edinadentalcare.com

3939 West 50th Street #208
Edina, Minnesota 55424
P: 952.922.2214

I hereby give you my permission to release any and all of my dental record.

_____

Signature Date

If not signed by the patient, please indicate relationship:

_____ Parent or guardian of minor patient

_____ Guardian or conservator of patient

_____ Beneficiary or personal representative of deceased patient