ElkRiver
FAMILY DENTISTRY

AUTHORIZATION FOR RELEASE OF:

Dental record information

(Name and Address of Patient)

_____

_____

_____

Birth date: _____

I hereby authorize (former dental office): _____

_____

_____

To release copies of my dental records. Please send or e-mail any x-rays you have within the last 5 years to:

Elk River Family Dentistry
303 Main Street
Elk River, MN 55330

e-mail: receptionist@elkriverfamilydentistry.com

_____ _____

(Date) (Signature of parent – if minor, patient)