ROBBINSDALE
DENTALCARE
HEALTH • COMMUNITY • COMPASSION

AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

Date: _____

I hereby authorize Robbinsdale DentalCare PA to release my dental records to:

Name: _____

Address: _____

_____

Email: _____

Patient Name (s) & DOB: _____

_____

_____

_____

Reason for transfer/request: _____

_____

Signature (Patient, Parent, or Guardian)

Robbinsdale DentalCare
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Robbinsdale, MN 55422
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763 535-0693 fax
info@robbinsdaledentalcare.com