

# Authorization of Release of Records

**Name, Address, Phone, E.mail, and Fax of Dentist we are Releasing Records to or Obtaining Records From:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**E.mail** \_\_\_\_\_

**Fax:** (     ) \_\_\_\_\_

**Phone:** (     ) \_\_\_\_\_

**Records Being Requested:**

\_\_\_\_\_  
\_\_\_\_\_

**Name of other Family Members you would like us to release/request records to/for:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Please send or **e.mail** requested records to/from:

Relaxation Dentistry  
1475 White Oak Drive #200  
Chaska, MN 55318  
(952) 351-8282  
Fax #(952)-466-2777  
[Dentist@RelaxationDentistryChaska.com](mailto:Dentist@RelaxationDentistryChaska.com)