Authorization of Release of Records

Name, Address, Phone, E.mail, and Fax of <u>dentist and office</u> 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**:_____

Reason for transferring

_____

_____

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

Relaxation Dentistry
1464 White Oak Drive
Chaska, MN 55318
Phone: (952) 351-8282
Fax: (952)-466-2777
contact@RDchaska.com