CHANHASSEN DENTAL
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CHANHASSEN DENTAL RELEASE OF RECORDS REQUEST

_____ _____, authorize my previous Dentist
(Patient name) (Date of birth)

_____ _____
(Dentist/Practice Name) (Street address)

_____
(City, State, Zip)

_____ _____
(Phone) (Fax)

To forward my dental records with respect to any dental care and treatment that I have received.

I understand that the specific type of information to be disclosed includes a detailed report of examinations, treatment provided, x-rays, and all other records which pertain to my dental health.

This consent is effective until such date that I choose, and I can cancel this consent at anytime. I understand that the information obtained as a result of this consent may be used after the cancellation date.

Signed: _____Date:_____
(Patient Name)

Signed: _____Date:_____
(Parent, legal guardian, or POA of the patient, if the patient is unable to sign for themselves)

Please send my records to the following address:

Name: _____

Street Address: _____

City/State/Zip: _____

Phone: _____

Email Address: _____