925 Hwy 55 Suite 104, Hastings MN 55033 ● (P) 651-437-5340 ● (F) 651-437-3780

Authorization for Release of Dental Records

Patient Name to Transfer:_____

Date of Birth:_____ Phone: _____

Other Family Members to Transfer: _____

_____

I authorize River Pines Dental to release my records to:

Dr. or Dental Office Name: _____

Address:_____Phone Number:_____

Fax Number:_____or Email:_____

I authorize River Pines Dental request my records from:

Dr. or Dental Office Name: _____

Address: _____Phone Number:_____

Fax Number:_____or Email:_____

Reason for request: □ Transferring dental offices □ Second Opinion □ Referred out □ Other

Signature of Patient or Guardian:_____ Date:_____

If records are digital please email to: frontdesk@riverpinesdental.com

*I understand that all information I hereby authorize to be obtained will be held strictly confidential and cannot be released without my written consent. I understand that this authorization will remain in effect until revoked by me in writing.