REQUEST FOR RELEASE OF PATIENT RECORDS

Patient Name: ______________________________

Date of Birth: ______________________ Phone: ______________________

Address: ______________________________

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Please include any family members who wish to transfer their records as well:

Patient Name: ______________________ Date of Birth: __________

Patient Name: ______________________ Date of Birth: __________

Patient Name: ______________________ Date of Birth: __________

Patient Name: ______________________ Date of Birth: __________

Patient Name: ______________________ Date of Birth: __________

I hereby authorize:

Clinic Name: ______________________________

Phone: ______________________ Fax: ______________________

City/State: ______________________________

To release any and all requested dental information, including copies of my dental record and radiographs, to:

☐ **Brenner Dental Group**
Buffalo, MN
Phone: 763-682-2101
Fax: 763-682-5069
Email: office@brennerdentalgroupmn.com

☐ **Clinic Name:** ______________________
City/State: ______________________
Phone: ______________________
Fax: ______________________
Email: ______________________

Reason for Leaving:

◯ Moving ◯ Insurance is out of network ◯ Hours of Operation ◯ Billing Problem

◯ Other (Please specify): ______________________________

Signature of **PATIENT**, **PARENT** or **GUARDIAN**: ______________________ Date: __________

Revised 1/1/2018