AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

I herby authorize [dentist/clinic name]_____
to release the information in the dental records for patient(s):

_____ Birthdate:_____

_____ Birthdate:_____

_____ Birthdate:_____

_____ Birthdate:_____

Please forward current films and any other pertinent dental/health information to (digital files are accepted):

Cornerstone Dental
14501 Granada Drive, #100
Apple Valley, MN 5512

Email: info@cornerstonedental.com
Phone: (952)432-1787
Fax: (952)432-1796

Signature:_____ Date:_____

If not signed by patient, please indicate relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of incompetent patient
- ☐ Beneficiary or personal representative of deceased patient