BRENNER
Family Dental

REQUEST FOR RELEASE OF PATIENT RECORDS

I hereby authorize you to release to:

Dentist/Clinic Name: _____

Address: _____

Phone/Fax: _____

Email: _____

Any and all requested dental information, including copies or Photostats of my dental record and radiographs, concerning treatment given to me at:

Brenner Family Dental
8900 Walnut Street, Suite 450 | PO Box 236
Rockford, MN 55373

OR

Main Street Dental of Rockford
6016 Main Street
Rockford, MN 55373

Name: _____ Date of Birth: _____

Please include the NAMES and BIRTHDATES of any family members you wish to include in this records release:

_____

_____

_____

Reason for Leaving:

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

◯ Other (Please specify) : _____

_____ _____

Signature of Patient, Parent or Guardian (if under 18) Today's Date