BRENNER Family Dental
8900 Walnut St. #450 | PO Box 236
Rockford, Minnesota 55373
(763)477-5794
www.brennerfamilydental.com

REQUEST FOR RELEASE OF PATIENT RECORDS

Patient's Name: _____ **DOB**: _____

Additional Family Members (if necessary):

Name: **DOB:**

_____ _____

_____ _____

_____ _____

_____ _____

Previous Dentist Name: _____

City/State: _____

Phone: _____

Fax: _____

I authorize the release of my dental and medical information to Brenner Family Dental (bitewings within 24 months, panoramic and/or full mouth series within 5 years).

Signature: _____**DATE**: _____

(of Patient, Parent or Guardian)

Please send digital x-rays to:

info@brennerfamilydental.com