

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

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