3205 West 76th St.
Edina, MN 55435

Phone 952-841-0122
Fax 952-896-0010

Request for Release of Dental Records to York Dental

Patient Information (to be completed by patient)

Patient Name: _____
First Middle Initial Last

Address: _____
Street Apt #

_____
City State Zip Code

Home Phone: (____) _____ Work Phone: (____) _____

Date of Birth: _____ Soc. Sec. No.: _____

Information Requested (to be completed by office)

Full Series Films within 5 years Date: _____

Bitewing Series within 1 year Date: _____

Please indicate any current recommendations or concerns: _____

_____

_____

Forwarding Address

Please forward requested information to:

_____

_____

_____

_____

I hereby authorize the release of all indicated information to: _____

_____
Signature of patient, parent, or legal guardian **Date**