RECORDS RELEASE/REQUEST

I hereby authorize the release of my dental records to the following address.

To____

Address____

City_____________________State________________Zip__________________

Email____

All information regarding any treatment in your office (a) between____________(dates) or (b) related to (name procedure(s) or treatment(s), condition, specific report(s)_________________

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may be released including, but not limited to, mental health records; drug and/or alcohol abuse records, which are protected by state or federal law; a HIV or test results and related health care issues, if any, except as specifically provided below.

Optional; I understand and agree to pay a reasonable charge to cover the cost of transfer, as allowed by MN Statue 144.355, Subd. 5. Since the charges change annually, call the Department of Health at (800) 657-3793 or at (651) 282-6314 for the most accurate amount.

This authorization is effective now and will remain effective until__________ (no longer than one year). I understand that I may receive a copy of this authorization before the year is over. I understand that I may receive a copy of this authorization.

Print Name of patient ____Date of birth____________

Signature ____ Date__________________

If not signed by patient, relationship to
____