Crow River Dental
Big Smiles!

RECORDS RELEASE

DATE: ____/_____/_____

I, _____ , authorize the release of my records, including x-rays and any/all information that is current that may be important to my ongoing care and treatment.

PLEASE FORWARD THESE RECORDS TO:
CROW RIVER DENTAL, P.A.
405 Babcock BLVD. East, Suite 130
Delano, MN 55328
763-276-1410
763-276-1411 (FAX)
Email: Smiles@crowriverdental.com

SIGNATURE: _____