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 the 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:____