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.

Release Records from: ____

____

____

PLEASE FORWARD THESE RECORDS TO: CROW RIVER DENTAL, P.A

405 BABCOCK BLVD. E. SUITE 130

DELANO, MN 55328

763-276-1410

763-276-1411 (FAX)

EMAIL: smiles@crowriverdental.com

SIGNATURE: ____