Menomonie Street Dental, LLC

Dental Records Release Form

I, _____ request the release of the following dental records:
PRINT NAME

PATIENT's NAME (please print below) First Name Middle Initial Last Name	DOB

Release records to (include e-mail address):

_____

_____

_____

Reason for Release:

_____

_____

If Scheduled in Another Office, Date of Appointment: _____

Please allow two (2) business days to process your request.

Signature of Patient (Parent or Guardian) _____

Relationship (if Parent or Guardian) _____

Date: _____

Phone #(____)_____

Patient's 18 years and older must sign their own release.

For Office Use Only:

Accepted by: _____ Date: _____

Scan Copy into EACH patient's chart.

1020 Menomonie Street ~ Eau Claire, WI 54703 ~ 715-834-8161 ~ www.MSDsmile.com

Dr. S.H. Van Gorden Dr. James Friedeck Dr. Eric Carlson Dr. Derek Rognlien Dr. Karilynn Peper Dr. Brittany Huiras

"Smiles created to make a lasting impression."