Scandia Family Dental
21080 Olinda Trail. N Suite 2
Scandia, MN 55073
Ph# 651-433-2655
Fax# 651-433-4098
Email: info@scandiafamily.com

Release of Dental Records

Patient Name _____ DOB____/____/_____

Patient Name _____ DOB____/____/_____

Patient Name _____ DOB____/____/_____

Information to be Disclosed:

_____Copy of Dental X-Rays _____ All Treatment Rendered _____ All Treatment Still Proposed

_____Other-Describe: _____

Name of Clinic Authorized to Make the Disclosure: _____

Clinic City & State: _____

Clinic Phone #: _____

Clinic E-mail Address: _____

***In consideration of such disclosure on the part of the above-named clinic, I hereby release them from any and all liability arising from disclosure.*

Name of Clinic Authorized to Receive the Disclosure: **Scandia Family Dental**

Clinic City & State: **21080 Olinda Trail N. Scandia, MN 55073**

Clinic Phone #: **651-433-2655**

Clinic E-mail Address: **info@scandiafamilydental.com**

Reason for Record Transfer:

_____ 2nd Opinion _____Relocated _____ Insurance Reasons

_____ Other (If other, we would appreciate knowing why)- _____

_____

Signature: _____ Date: _____ / _____ / _____

Print Name: _____ Relation to Patient: *Self or Guardian*

For Office Use Only-

Date Records Copied and Sent: ___/___/____ By Whom: _____ Account Balance Cleared: _____