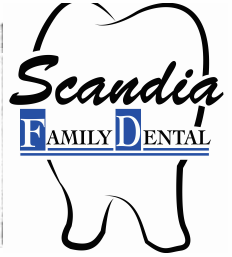


**Scandia Family Dental**

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:**

\_\_\_\_ 2<sup>nd</sup> 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:* \_\_\_\_\_