Authorization To Release Dental Records

Name and Address of Previous Dentist: **Date:_____**

Chanhassen Dental
P. O. Box 189
Chanhassen, MN 55317
952-934-3383-office
952-934-6668-fax

_____ Please send current radiographs and records to:

_____
_____
_____
_____

_____ Records Released to Patient:

_____

_____
Signature