1616 Franklin St. N
Glenwood, MN 56334

Phone (320)634-3556
dhsminnewaska@gmail.com

Authorization for Release of Records and X-rays

Date _____

To _____
Doctor / Physician / Clinic Name

Address _____ City_____ State _____ Zip _____

Phone _____ Fax _____ Email _____

I authorize the release of dental records and x-rays relevant to dental treatment, and request that they be transferred to:

Dental Health Services

Email: dhsminnewaska@gmail.com

Fax: (320) 634-3567

Patient Name _____ DOB _____

Additional Family Members to be Included:

Patient Name _____ DOB _____

Patient Name _____ DOB _____

Patient Name _____ DOB _____

Signature_____ Date _____
Patient / Guardian Signature