Authorization For Release of Dental Record

NAME OF PATIENT____**DOB**_______________________

ADDRESS OF PATIENT

I HEREBY AUTHORIZE ____**TO RELEASE MY MEDICAL AND DENTAL INFORMATION TO:**

Omega Dental Care, P.A.
6203 Dell Rd.
Eden Prairie, MN 55346
P: 952.937.5977
F: 952.487.1475

The Information To Be Disclosed Is:

______ **Medical/dental History**

______ **Treatment/progress Notes**

______ **Dental X-rays**

______ **Other**
____

Signature Of Patient____**date**_____________

{Parent or Guardian if patient is a minor}