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320-392-5300
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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:

Hancock Dental

Email: hancockdentalmn@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

Complete Family Dentistry with Emphasis on Prevention