MAGNOLIA DENTAL

DENTAL RECORD RELEASE FORM

I, _____ , (patient's name) hereby authorize
_____ (former dentist's name) to provide
_____ (new dentist's name) with copies
of my dental records with respect to any dental care and treatment that I have received.

I understand that the specific type of information to be disclosed includes a detailed report on examination, treatment provided, x-rays and all other records which pertain to me.

Signed: _____
(Patient)

Signed: _____
(Parent, legal guardian, or POA of the patient, if the patient is unable to sign for themselves)

Please send records to:

Practice Name: _____

Practice Address: _____

_____

(262) 783-3311
Frontdesk@MagnoliaDentalWI.com
14335 W Capitol Drive
Brookfield, WI 53005