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Authorization of Release of Dental Records and Xray's

Patient Name: _____ Patient Date of Birth: _____

Requesting records of:

☐ Pan ☐ FMX ☐ BW'S ☐ Other (Specify):_____

Date of records requested: From: _____ To: _____

I request my records be transferred from:

Name: _____
Address: _____
Email Address/ Fax Number: _____

To:
Calcagno Cosmetic and Family Dentistry
1801 Greenview Drive SW
Rochester, MN 55902
whitesmiles@calcagnodds.net
Fax: 507-536-9790

If this request is by the patient:
Patient Signature: _____ Date: _____

If this request is by the patient's legal guardian:

Legal Guardian name (print): _____ Relationship to patient _____

Signature of Legal Guardian: _____ Date: _____

By signing I certify I have the legal authority under federal and state law to make this request on behalf of the patient identified above.

If you have any questions about his form, please feel free to contact our office. Thank you!