OAK PARK
DENTAL

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Authorization for Records Release

Patient Name: ________________________________ **D.O.B**: ______________

Additional Family Members to be released:

____ D.O.B: _______________

____ D.O.B: _______________

____ D.O.B: _______________

I authorize records to be released from:

Office Name: __________________________________

Address: __________________________________

City/State/Zip __________________________________

Phone: __________________________________

Email (if avail) __________________________________

I authorize records to be released to:

Oak Park Dental
505 Johnson Ave SE
Pine City, MN 55063
320-629-2282
info@oakparkdentalmn.com

_______________________________________ _______________________

Signature (Patient, Parent or Guardian) Date