CrimsonCare
FAMILY DENTAL

Authorization for Release of Dental Records and X-rays

I, (print patient or guardian name) ____, hereby

Authorize the doctors and staff of ____
(name of previous clinic)

To release records or knowledge concerning my dental health to:

CrimsonCare Family Dental
9507 Blackoaks Lane North
Maple Grove, MN 55311
Email: info@crimsoncaredental.com
Phone: 763-416-2006
Fax: 763-416-2010

I specifically request that you release copies of all x-rays and all treatment notes.

Signed (patient or guardian name) ____

Printed name (patient or guardian name) ____

Date: _________________________________