Grand Avenue Dental, LLC
960 Grand Avenue
St. Paul, MN 55105
651-291-9667

Chart # _____ (office use only)

RECORDS RELEASE FORM

I am requesting that a copy of my/our records, as indicated below, be sent to the following address, e-mail or fax:

Grand Avenue Dental, LLC
Dr. Paul Amble
960 Grand Avenue
St. Paul, MN 5105

Fax: 952-955-9783

E-mail: info@grandavenuedental.com

Patient Name(s) and Date(s) of birth

_____

_____

_____

Records requested are circled:

- Complete set of chart notes and periodontal probing
- Most recent set of bitewing radiographs
- Most recent set of full mouth or panoramic radiographs

I authorize the release of my/our dental records. If this request is for a minor (under the age of 18 years), I certify that I am the minor's parent and/or legal guardian. A facsimile copy of this request and signature will be treated as the original.

_____ Date _____
Signature of Patient or Patient's Representative

If signed by patient's representative:

_____ _____
Print representative's name Relationship to patient