AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

Name: _____ DOB: _____

I hereby authorize _____,

Fax: _____ Phone: _____

Email: _____,

to release my most recent BWXs, FMXs, Panoramic X-Rays, and any other pertinent records to:

Grand Marais Family Dentistry, P.A.
P.O. Box 670
Grand Marais, MN, 55604

info@grandmaraisfamilydentistry.com (email preferred, please)

tel: 218-387-2774 fax: 218-387-1393

This authorization, as may be applicable, extends to any medical records covered by any privilege, including without limitation to psychiatric, psychological and mental testing and records; records relating to drug treatment and/or substance abuse; records related to sexually transmitted diseases and/or social service notes.

Patient Signature: _____ Date: _____

AUTHORIZATION EXPIRES ONE YEAR AFTER SIGNED