101 South Park Avenue - P.O. Box 97
Le Center, MN 56057
Office (507) 357-4982
Fax (507) 357-2287
www.lecenterdentalclinic.com

RELEASE OF RECORDS REQUEST

DATE: ____________________

TO: ____
(Previous Doctor)

ADDRESS: ____

CITY: ______________________ STATE: _________ZIP:_________________

I authorize the release of dental records, x-rays (bitewings, full mouth series/panoramic), and medical records relevant to dental treatment, or copies of such and request that they are referred to:

LE CENTER DENTAL CLINIC
101 SOUTH PARK AVENUE – P.O. BOX 97
LE CENTER, MN 56057

____	____
PRINT NAME of PATIENT	**DATE of BIRTH**
____	____
SIGNATURE (PATIENT/PARENT or GUARDIAN)	**DATE**
____	____
PRINT NAME of PATIENT	**DATE of BIRTH**
____	____
SIGNATURE (PATIENT/PARENT or GUARDIAN)	**DATE**
____	____
PRINT NAME of PATIENT	**DATE of BIRTH**
____	____
SIGNATURE (PATIENT/PARENT or GUARDIAN)	**DATE**

info@lecenterdentalclinic.com