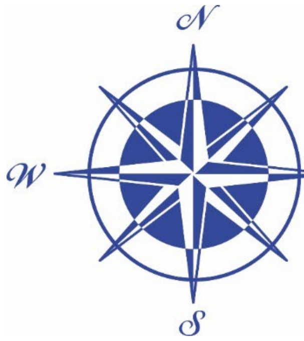


DRESEN
Restorative Dentistry

## Records Release Request

**DATE: ________________**

**Name of Dental Practice requesting records to be released FROM:**

**______________________________________________**

**PRACTICE ADDRESS: _______________________________________________**

**CITY: __________________ STATE: _____ ZIP: ____________**

**Dental Practice Email: __________________________________________**

**Name of Dental Practice requesting records to be released TO:**

**_______________________________________________**

**Dental Practice Email Address: ______________________________**

*PATIENT PRINTED NAME:__________________________________*

*AUTHORIZES THE RELEASE OF DENTAL RECORDS RELEVENT TO DENTAL TREATMENT, INCLUDING ALL CURRENT DENTAL RADIOGRAPHS AND REQUESTS THEY BE TRANSFERRED.*

**SIGNATURE______________________________________________**

**Dresen Restorative Dentistry- Dr. Thomas Dresen**

**1000 Radio Drive, Suite 110 Woodbury, MN 55125**

Info@dresendentistry.com **651-735-1585**