REQUEST FOR RELEASE HEALTH RECORDS

Patient name: ____ hereby grant permission to

____
(Previous Dentist name)

To release information related to my health history, status, and treatment, and copies of my health record, x-rays and any test results to:

Steven R. Hagerman D.D.S.
1605 W. Minnehaha Ave. #101
St. Paul, MN 55104
Or
HagermanDentalCare@gmail.com

Patient
Signature____date_____________________
(If minor, parent or guardian must sign)