# AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Patient name: _____ Date of Birth: _____

I hereby consent to the release of my dental records as follows:
(Initial each that you authorize.)

_____ Release of my records from my previous dental clinic to River Valley Dental of Mankato.

_____ Release of my records from River Valley Dental of Mankato to my new dental clinic.

I understand that records can include dental radiographs (x-rays), treatment completed, treatment recommended, dental chart information, and the dates of these services.

By signing below I understand that I can revoke this authorization at any time.

Signature Date

Relationship if patient is a minor:_____