945 Echo Dr. SE
Hutchinson, MN. 55350
320-587-2769

Authorization for the Release of Dental Records From:

I hereby authorize _____

_____

To release all dental records to Echo Family Dental for:

Patient name (s) _____

_____

The purpose for this release of health/dental information is: _____

All information regarding my treatment in your office including charting, referral and x-rays. I understand that I may receive a copy of the authorization.

_____ _____
Signature Date

If not by the patient please indicate relationship:
_____Parent or Guardian of minor patient
_____Guardian or Conservator of an incompetent patient
_____Beneficiary or Personal Representative of deceased patient

Phone: (320) 587-2769 Fax: (320)587-0321

Email x-rays to: office@echofamilydental.com