Consent Form to Release Health Information
To Dental Arts of Minneapolis

Please complete, sign, and fax or email to us.

Date ____________________

Records request for ___________________ DOB ________________________
Previous name if applicable_________________
Address ____
Phone ______________________

To the office of: Dental Arts of Minneapolis
825 Nicollet Mall #425
Minneapolis, MN 55402
P: 612-332-7675 F: 612-305-1861
Email: daminneapolis@mydentalmail.com

I, _________________, am requesting and hereby give my permission for the transfer of my records to:
Dr Name____
Address: ____
Phone: ____
Fax: ____
Email: ____

Health information to be released:

-Most recent perio charting
-Most recent bitewings
-Most recent full-mouth series
-Implant info (system, sx & Restored date)
-Periodontal hx (dates of srp /sx)

Reason for releasing information

○ Patient request	○ Legal
○ Review of current care	○ Payment
○ Treatment / continued care	○ Insurance application / request

I understand that by signing this form, I am requesting that the health information specified above to be sent to the third party named above.
I may stop this consent at any time by writing to Dental Arts of Minneapolis.

The consent will end one year from the date the form is signed unless I indicate an earlier date or event here (ie: "60 days after leave the hospital", "once the health information is sent".)
(optional) Date_________________ OR specific event___________________________________

Signature Date

OR ____
Legal authorized representative signature Relationship to patient Date