Metro Dentalcare

44 South Saint Croix Trail
Suite 100
Lakeland, MN 55043
651-436-5177
mdclakeland@mydentalmail.com

Request for Release of Records

I hearby authorize the release of my dental records or copies of such and request they are transferred to:

To: (Clinic Name)_____

Email Address: _____

Mailing Address_____

City_____ State_____ Zip_____

Today's Date: _____

Patient Name:_____

Patient Date of Birth:_____

Patient Signature: _____

Guardian Name if signing for minor: _____