

**429 Commerce Drive  
Suite 400  
Woodbury, MN 55125  
651-731-2342  
mdcwoodbury@mydentalmail.com**

## **Request for Release of Records**

**I hereby 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: \_\_\_\_\_