Ham Lake Dental
16220 Aberdeen St. NE Suite A1
Ham Lake, MN 55304
Ph# 763-434-4188
Fax# 763413-7261
E-mail: Xrays@HamLakeDental.com

Release of Dental Records

Patient Name ____DOB_____/_____/______

Patient Name ____DOB_____/_____/______

Patient Name ____DOB_____/_____/______

Information to be Disclosed:

_____Copy of Dental X-Rays _____ All Treatment Rendered _____ All Treatment Still Proposed

_____Other-Describe: ____

Name of Clinic Authorized to Make the Disclosure: ____

Clinic City & State: ____

Clinic Phone #: ____

Clinic E-mail Address: ____

***In consideration of such disclosure on the part of the above-named clinic, I hereby release them from any and all liability arising from disclosure.*

Name of Clinic Authorized to Receive the Disclosure: Ham Lake Dental

Clinic City & State: 16220 Aberdeen Street NE #A1, Ham Lake, MN 55304

Clinic Phone #: 763-434-4188

Clinic E-mail Address: Xrays@hamlakedental.com

This Authorization Will: ☐ Not Expire ☐ Expires On: _____ /_____ /______

Reason for Record Transfer:

_____ 2nd Opinion _____Relocated _____ Insurance Reasons

_____ Other (If other, we would appreciate knowing why)- ________________________________

____

Signature: ____ **Date:** _______ / _______ / ________

Print Name: ____ **Relation to Patient:** *Self or Guardian*

For Office Use Only-

Date Records Copied and Sent: ____/ ____/ _____ By Whom: ______ Account Balance Cleared: ______