Creekside Dental
Dr. Patrick Foy D.D.S
Dr. Nancy Hamilton D.D.S

Release of Records Authorization

I, _____ authorize the release of dental records relevant to dental treatment, or copies of such, and request that they be transferred.

Please Transfer to: (select one)

- ○ Creekside Dental contactus@creeksidedentalmn.com; 952-938-2740
- ○ Name of office: _____

Office Phone/Email: _____

From: (select one)

- ○ Creekside Dental contactus@creeksidedentalmn.com; 952-938-2740
- ○ Name of office: _____

Office Phone/Email: _____

Patient: _____ Date of Birth: _____

Patient: _____ Date of Birth: _____

Patient: _____ Date of Birth: _____

Patient: _____ Date of Birth: _____

(Patients 18 years of age and older must sign for themselves)

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

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