Creekside Dental

Dr. Gabriel De Los Rios
Dr. Nancy Hamilton
Dr. Bruce Hansen

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: ____

New office email (*REQUIRED or records will not be sent:)

____

New office phone number:____

From: (select one)

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

Office Phone/Email: ____

Print name:____________________________________ **Date of birth**:_______________________

Print name:____________________________________ Date of birth:_______________________

Print name:____________________________________ Date of birth:_______________________

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

Signature:_____________________________________ **Today's Date**:_______________________

Signature:_____________________________________ Today's Date:_______________________

Signature:_____________________________________ Today's Date:_______________________

Creekside Dental
3340 Republic Ave, Ste 130
St. Louis Park, MN 55426

952-938-2740
contactus@creeksidedentalmn.com
www.creeksidedentalmn.com