ELK DENTAL CENTER

RELEASE OF DENTAL RECORDS

I am requesting to have the Dental Records of the below patients transferred:

Name(s) & DOB(s)

_____ _____

_____ _____

_____ _____

Reason for Transfer: _____

Please Transfer Records TO:

Elk Dental Center
staff@elkdentalcenter.com
822 Main Street NW - Suite A
Elk River, MN 55330
Phone 763-441-2170
Fax 763-441-9045

FROM:

_____

_____

_____

_____

_____

_____

SIGNATURE _____ **DATE** _____