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:

_____

_____

_____

_____

_____

_____

FROM:

Elk Dental Center

staff@elkdentalcenter.com

822 Main Street NW - Suite A

Elk River, MN 55330

SIGNATURE _____ **DATE** _____