Consent for Release of Information

I, ________________________________ hereby authorize the following dental
(Print Patient Name)
practice:

Practice Name: _______________________________________

Address: ____

City/State/Zip: _________________________________

Phone: ____

To release and forward all of my dental records to the following address:

Great River Dentistry of Bemidji, PLLC
P.O. Box 1005
Bemidji, MN 56619
(218) 751-4216
Fax: (218) 444-6057
Email: contactus@greatriverdentistry.net

_________________________________ **_________________**
Patient Signature **Date**