Kruckman
FAMILY DENTISTRY

Authorization Form

Authorization of Release of Records

Name, Address, Phone, Email, and Fax of the Dentist we are Releasing Records to or Obtaining Records From:

Name of office:____

Address: ____

____

Email: ____

Fax #: ____

Phone #: ____

Name / Date of Birth of Family Members you would like us to release/request

Name:____________________________________ DOB ______________

Name:____________________________________ DOB ______________

Name:____________________________________ DOB ______________

SIGNATURE ________________________________ Date ______________

Please send or email requested records to/from
Kruckman Family Dentistry
576 Cherry Dr.
Waconia, MN 55387
952-679-4461