Brandon C. Helgeson, DDS
Lisa A. Edstrom, DDS

AUTHORIZATION TO RELEASE DENTAL RECORDS INFORMATION

I, _____, DOB _____ on Date _____
Request :
Practice Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Office Number: _____ Fax Number: _____
Email: _____

I Authorize to Release My Dental Records to:

All dental sources, including any health plan, dentist, health care professional, dental facility or other health care provider(s) that has provided payment, treatment or services to me or on my behalf.

Denmark Dental
1519 Central Parkway
Suite 240
Eagan, MN 55121
info@denmarkdental.com
Office: 651-452-4455 Fax: 651-452-1270

This Release Includes Family Members (If Applicable):
Name: _____ DOB: _____
Name: _____ DOB: _____
Name: _____ DOB: _____
Name: _____ DOB: _____

Please Release the Following Documentation:
- ❒ Complete Chart
- ❒ Consultations
- ❒ X-rays
- ❒ Other: _____

This authorization, as may be applicable, extends to any dental records covered by privilege.

_____
Patient/Parent/Legal Guardian Date

_____
Doctor Signature Date

Office Use Only – Date of X-rays
BWX: _____
FMX: _____
Pano: _____
Other: _____

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