STAR DENTAL

Sleep • TMJ • Airway • Restorative

Release of Information

Today's Date: _____

I,_____ (DOB)_____, hereby authorize Dr. Whitney Davidson and staff of Star Dental to release dental x-rays and any further requested records to:

Office/Doctor: _____

Address: _____

Phone:_____ Fax:_____

Email:_____

☐ I request my X-Ray/Images be sent to requested provider

☐ I request my records be sent to requested provider

Additional records I am requesting to be shared:

_____

_____

_____

_____

I also request release for my child(ren) that are under the age of 18:

_____

Signature:_____ Date:_____

Dr. Whitney Davidson, BSN, DDS
201 South Meridian Street
Belle Plaine, MN 56011
P: 952.873.6766 F: 952.873.5489
www.stardentalhealth.com
E: info@stardentalhealth.com