DENTAL RECORDS RELEASE AUTHORIZATION

(PLEASE COMPLETE AND RETURN)

for

THE DENTIST'S HOUSE OF EDINA

"a comfortable approach to dentistry"

Janet A. Zingale, DDS and Michael J. Zingale, DDS

I HEREBY REQUEST AND AUTHORIZE:

*DENTAL OFFICE*_____

ADDRESS _____

_____

TO RELEASE COPIED CLINICAL DENTAL RECORDS INCLUDING DENTAL RADIOGRAPHS OF THE FOLLOWING INDIVIDUALS ***(PLEASE DO NOT REQUEST FOR INDIVIDUALS AT OR OVER THE AGE OF 18, THEY WILL HAVE TO MAKE THE REQUEST THEMSELVES)***

_____ *DOB*_____ *RELATIONSHIP*_____ _____ *DOB*_____ *RELATIONSHIP*_____

_____ *DOB*_____ *RELATIONSHIP*_____ _____ *DOB*_____ *RELATIONSHIP*_____

_____ *DOB*_____ *RELATIONSHIP*_____ _____ *DOB*_____ *RELATIONSHIP*_____

AND SEND THEM TO:

NAME *The Dentist's House of Edina*

ADDRESS *3930 SUNNYSIDE ROAD* *PHONE NUMBER: 952-929-9131*
EDINA, MN 55424

I ACCEPT AND AGREE THAT THE DENTIST'S HOUSE OF EDINA, INC WILL MAKE A GOOD-FAITH ATTEMPT TO FOLLOW THE HEALTH INFORMATION PRIVACY POLICIES AND PROCEDURES.

_____ _____
SIGNATURE OF PATIENT/OR LEGAL GUARDIAN *DATE*

_____ _____
THE DENTIST'S HOUSE OF EDINA STAFF *DATE RECEIVED*

Thank you and have a nice day.