



John Woell, DDS  
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## AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Patient Address \_\_\_\_\_

I hereby authorize \_\_\_\_\_  
(Name of dentist or clinic)

\_\_\_\_\_  
(Address of Dental Clinic)

\_\_\_\_\_  
(Phone # of Dental Clinic)

To release all Dental/Medical information to:

**DENTAL HEALTH CARE CENTER, P.A.  
1717 EAST 66<sup>TH</sup> STREET  
RICHFIELD, MN 55423**

Email: [Appointments@dentalhealthcarecenter.com](mailto:Appointments@dentalhealthcarecenter.com)

The information to be released:

- Current radiographs (Bitewing, Full Mouth, Panorex, and or Periapical)  
 Periodontal Probe Charting and/or Chart Notes

I understand that I may revoke this authorization at any time.

\_\_\_\_\_  
Name of Patient/Guardian

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date