dhcc
Dental Health Care Center

John Woell, DDS
Elizabeth Woell Rhode, DDS

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 66TH STREET
RICHFIELD, MN 55423
612-861-7109

Email: 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