



RIVERSIDE DENTAL CARE

Family and Cosmetic Dentistry

Dental Release of Records Form

I hereby authorize _____ to release the
(Dentist name)

dental records of _____ , _____
(Patient's name) (Date of birth)

to Riverside Dental Care. The records will include copies of all current x-rays.

Please send physical x-rays to:

Riverside Dental Care
217 Nassau St.
PO Box 448
Saint Peter, MN 56082

Please send digital x-rays to:

xray@riversidedentalcarespeter.com

Call with questions: 507-931-5646

Patient Signature (Parent, if a minor)

Date