Consent Form to Release Dental Images/Records

Patient Information:

First Name _____ M.I. _____ Last Name _____

Patient date of birth ___/___/_____

Home address _____

City _____ State _____ Zip Code _____

Phone _____

Additional Patients (optional):

First, M.I., Last _____Birthdate ___/___/_____

First, M.I., Last _____Birthdate ___/___/_____

First, M.I., Last _____Birthdate ___/___/_____

First, M.I., Last _____Birthdate ___/___/_____

Requesting Dental Images from:

Dental Clinic name _____

Address _____

Phone _____ Fax _____

Requesting Dental Images be sent to:

Info@DentistEP.com

Robert E Derr, DDS & Amy Chi, DDS Family Dentistry
7825 Terrey Pine Court, Ste. 201
Eden Prairie, MN 55347
Phone (952)934-3569
Fax (952)934-3586

Patient (or legal representative) Signature _____

Date ___/___/_____

Representative's relationship to patient (parent, guardian, etc.) _____