RECORD RELEASE

I HEREBY AUTHORIZE DOCTOR: _____

OF _____
(Street) (City) (State) (Zip)

TO FURNISH THE RECORDS IN YOUR POSSESSION CONCERNING MY CONDITION, AND/OR TREATMENT: INCLUDING X-RAY (S), PRESCRIPTIONS, PROGRESS NOTES, LAB REPORTS AND ANY OTHER TECHNICAL INFORMATION USED IN ASSESSING MY HEALTH & DENTAL CONDITIONS.

RELEASE TO:

HAMANN DENTISTRY
MICHAEL L. HAMANN, DDS, PA
200 FIRST AVENUE S
PERHAM, MN 56573
PHONE (218) 346-4775
FAX (218) 346-5775
EMAIL: MLHAMANNDDS@ARVIG.NET

PATIENTS NAME:
ADDRESS:
ADDRESS:
CITY/STATE/ZIP:
BIRTHDATE:

REQUESTED BY: _____

_____
(Signed)