Muna Abudayyeh, DMD
1801 Greenview Dr. SW Suite 101
Rochester, MN 55902

Office 507.281.3659
Fax 507.536.9790
whitesmiles@greenviewdental.net

GREENVIEW
Cosmetic and Family Dentistry

Authorization for Release of Dental Records and X-rays

Patient Name: _____ Date of Birth: _____

Requested records: Date(s) of records requested: _____

____FMX ____Panorex ____BW ____Other: _____

I authorize the release of my dental records from:

Office Name: _____

Address: _____

Phone: _____

To: Greenview Cosmetic and Family Dentistry
1801 Greenview Dr. SW
Rochester, MN 55902

Patient Signature: _____ Date: _____

If this request is by the patient's legal guardian:

Guardian Name (print): _____ Relationship: _____

Signature of Legal Guardian: _____ Date: _____

By signing, I certify that I have the legal authority under federal and state law to make this request on behalf of the patient identified above.