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

Office 507.281.3659
Fax 507.536.9790
whitesmiles@greenviewdental.net

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:

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

To: Office Name: ____

Address: ____

Phone: _____________________________

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.