V Dental Center

Office: 763-422-2000
Fax: 763-427-5770
vdentalcenter@comcast.net

Authorization to Release Records

I authorize the release of all current dental films and records to **V DENTAL CENTER**. Please mail films or e-mail (JPG format) files to the following:

V Dental Center
3903 Coon Rapids Blvd.
Coon Rapids, MN 55433
Vdentalcenter@comcast.net (jpg file format only)

Printed Name: ______________________________________ DOB: ______________________

First/last names and the birthdays for family members transferring to V Dental Center:

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If there are any questions, please contact me at (phone #): ________________________________

Previous Dental Office Name: ____

Previous Dental Office Phone #: ________________________ Fax#: ____________________

Previous Dental Office Email: ____

Thank You,

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(Your Signature) (Date)