Bicknell & Lehn Family Dentistry
311 N. 1st St.
Cold Spring, MN 56320
(320) 685-8891
Fax (320) 685-5321
Office@coldspringdentists.com

AUTHORIZATION FOR THE RELEASE OF DENTAL RECORDS AND X-RAYS

Name_____

Address_____

Date of birth____/____/_____

Telephone number_____

_____ Release ***To*** Bicknell & Lehn Family Dentistry
I hereby authorize the release of my dental records and X-rays to Bicknell Family Dentistry from the following clinic:

Name of clinic/Doctor: _____
Address: _____
Phone: ( ) _____Fax: ( ) _____

_____ Release ***From*** Bicknell & Lehn Family Dentistry
I hereby Request that Bicknell Family Dentistry release my dental records and X-rays to the following clinic:

Name of clinic/Doctor: _____
Address: _____
Phone: ( ) _____Fax: ( ) _____

Reason For Leaving Clinic: _____

Please read the following statements carefully
Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information.

Notice of Privacy Practices: You have the right to read our Notice of Privacy practices before you sign this consent.

I, _____, have had full opportunity to read and consider the contents of

this consent form. Date_____

If this consent is signed by a personal representative, on behalf of the patient, Please complete the following:
Personal Representative's Name: _____