Buffalo Dental Group

AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

Date ___________________________

I hereby authorize you to release my records to:

Buffalo Dental Group
1000 Highway 25 South
Buffalo, MN 55313
Phone: 763.682.2363
E-mail: Buffalodental2363@gmail.com

Name of Previous Dental Office ____

Address ____

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Patient(s)& DOB ______________________________

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Signature (Patient, Parent, or Guardian)
(DO NOT PRINT)