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: Info@Buffalodentalgroup.com

Name of Previous Office_____

Address_____

Patient(s) and DOB_____

_____

Signature (Patient, Parent, or Guardian)