West River Dental **Family & Cosmetic**

John R. Jordan D.D.S.
Nathan Jorgenson D.D.S.

1106 West River Road
Detroit Lakes, MN. 56501
(218)846-1900

Authorization for the request of patient health information from outside health care providers

Consent to release request for patient dental records

I, _____ hereby request and authorize _____
(Patient name) (Doctor Name)

To release to West River Dental all information in my record and in the record(s) of my Dependent(s), including current and previous dental records from other practitioners and/or clinics that are part of my record.

Copies of the following records are specifically requested:

- **Radiographs**
- **Progress Notes**
- **Periodontal and Dental Charting**
- **Letters/Reports to/from Specialists**

Patient Name:_____ **Date:** _____

Date of Birth: _____

Authorized Signature: _____

Dependents:

1. Patient Name: _____ Relationship: _____
   Date of Birth: _____/_____/_____

2. Patient Name: _____ Relationship: _____
   Date of Birth: _____/_____/_____

3. Patient Name: _____ Relationship: _____
   Date of Birth: _____/_____/_____

4. Patient Name: _____ Relationship: _____
   Date of Birth: _____/_____/_____

Please forward any records to this address:
West River Dental Family and Cosmetic
1106 West River Road
Detroit Lakes, MN 56501

Email Address:
smiles@westriverdental.com