RECORDS RELEASE

I, (name) ________________________ (date of birth)________________ authorize the release of my/our dental records from:

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To:

EAGAN VALLEY DENTAL CENTER, P.A.

Eagan Location:
4555 Erin Drive, Suite #180
Eagan, MN 55122
Phone: 651-681-9044
Fax: 651-681-0599
E-MAIL: smile@eaganvalleydental.com

Apple Valley Location:
14050 Pilot Knob Road Suite # 108
Apple Valley, MN 55124
Phone: 952-423-4414
Fax: 952-683-9316
E-MAIL: teeth@eaganvalleydental.com

Burnsville Ake Location:
12401 Nicollet Avenue
Burnsville, MN 55337
Phone: 952-890-4255
Fax: 952-882-7726
E-MAIL: corrine@eaganvalleydental.com

Burnsville Ridges Location:
625 East Nicollet Avenue Suite #202
Burnsville, MN 55337
Phone: 952-435-0300
Fax: 952-435-0360
E-MAIL: ridges@eaganvalleydental.com

Additional family members (name and date of birth)

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Signature______________________________ Date: ______________________________