

Eggert Family Dentistry

Elizabeth C. Eggert, DDS

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Patient Request for Records Release

Date _____

I hereby authorize and request that my dental records be released to
Eggert Family Dentistry, PA
at the address listed above

This includes any and all records and information, including, but not limited to dental radiographs, dental chart notes, dental and medical histories, and diagnostic models.

Patient Name _____

Signature _____

Parent or Guardian Signature if Under 18 _____