TRANQUILITY DENTAL
TRUST. RELAX. SMILE.

AUTHORIZATION OF RELEASE OF RECORDS

Name of previous dental office _____

Address _____

Phone _____ Fax _____

Patient(s) Name and Date of Birth & Records to be Released

_____

_____

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_____

I hereby authorize you to release my dental records to:

Tranquility Dental
7415 Wayzata Blvd Ste 201
St. Louis Park, MN 55426
Phone: 952.334.3304
Fax: 952.546.1123
info@tranquilitydentalmn.com

Patient Signature_____ Date_____