SAINT CITY
DENTAL

CONFIDENTIAL

RECORD RELEASE REQUEST
Previous Dental Office Information

Office Name:_____

Phone Number: _____

Patient(s) Name: _____

Date of Birth: _____

Patient/Guardian Signature: _____

Date:_____

I am requesting and authorizing the release of current dental x-rays and records to be transferred to the following address:

Saint City Dental
1150 Montreal Ave. Suite 104
St. Paul, MN 55116
Phone: 651-224-0001
Fax: 651-224-9958
Email: Info@saintcitydental.com