DENTAL RECORDS RELEASE FORM
JOHNSON FAMILY DENTAL CARE
PAUL D. JOHNSON, DDS & BART P. JOHNSON, DDS, AMY J. FULL, DDS
401 JEWETT STREET
MARSHALL, MN 56258
PHONE: 507-532-3104
FAX: 507-537-1347

I,_____authorize all patient chart information including patient history, radiographs and correspondence with dental specialists for each person listed below to be released to:

JOHNSON FAMILY DENTAL CARE
401 JEWETT STREET
MARSHALL, MN 56258

Please Send Digital Images To:
referrals@johnsonfamilydentalcare.com

First Name:_____Last Name:_____DOB:____
First Name:_____Last Name:_____DOB:____
First Name:_____Last Name:_____DOB:____
First Name:_____Last Name:_____DOB:____
First Name:_____Last Name:_____DOB:____

SIGNATURE_____DATE_____

Indicate which Dental Office you would like us to retrieve records from or sent to and how you would like your digital images sent:

Dental Provider Name_____
Phone_____ Fax_____
Email_____

If E-mail is not an option please indicate how to send records:
__ Hard Copy (paper)
__ USB

***This will be completed within 30 days.**