ZANE DENTAL
IMPLANT • COSMETIC • ORTHODONTIC

Records Release Request

Please complete and deliver (mail, fax, drop off, email) to your previous dentist if you would like any x-rays or records transferred to our practice.

I authorize the release of dental records and medical records relevant to dental treatment, or copies of such, and request they be transferred via mail or email to:

Zane Dental, llc
7340 Zane Ave N.
Brooklyn Park, MN 55443
Phone: 763-561-1200
Email: info@zanedentalmn.com

Name: _____ Signature : _____

Date of Birth:_____ Date: _____

Dependents (under 18)	Date of Birth
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____