2395 Troop Drive, Suite #101 | Sartell, Minnesota 56377
320.252.6191 | www.lawsonfamilydental.com

Consent to Release Dental Information

Patient Name: ______________________________________

Date of Birth: _____________ Phone #: __________________

I hereby authorize Lawson Family Dental to disclose to the following individual(s) all dental information on file, including but not limited to:

- entire dental record
- any insurance claim information
- any payment/billing/account information

Name	Phone Number	Relationship
Name	Phone Number	Relationship
Name	Phone Number	Relationship

I understand that I have the right to receive a copy of this authorization. I understand that I can revoke all or part of this authorization at any time except for parts that were released before I revoked it. I understand that when my dental information is released, it will no longer be protected by Lawson Family Dental.

I also acknowledge that this Authorization is a One-Time Authorization Only. Any additional access to my dental records will require a new Authorization.

Signature of patient/Responsible party: ______________________ Date: ____________
Relationship to patient: ________________