Dental Records Release Request

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

Marshall Dental Excellence
1106 E College Dr
Marshall, MN 56258

Please send digital images to:
info@frerichdds.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:** _______________________

Please indicate which dental office you would like us to request records from or sent to:

Dental Provider/Office Name:____

Phone: ____

Email: ____

Fax: ____