Records Release

I, (name) ________________________________ (date of birth) ____________ authorize the release of my/our dental records from/to:

Previous DDS:_____________________________

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(Please circle clinic)

Mosaic Dental -Eagan Valley
4555 Erin Drive Suite # 180
Eagan, MN 55122
Phone: 651-681-9044
Fax: 651-681-0599
Email: smile@mosaicdentalmn.com

Mosaic Dental – Apple Valley
14050 Pilot Knob Road Suite #108
Apple Valley, MN 55124
Phone: 952-423-4414
Fax: 952-683-9316
Email: teeth@mosaicdentalmn.com

Mosaic Dental-Nicollet
12401 Nicollet Avenue
Burnsville, MN 55337
Phone: 952-890-4255
Fax: 952-882-7726
Email: bv@mosaicdentalmn.com

Mosaic Dental-Ridges
625 Nicollet Blvd East Suite #201
Burnsville, MN 55337
Phone: 952-435-0300
Fax: 952-435-0369
Email: ridges@mosaicdentalmn.com

Additional family members (name and date of birth)

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Signature ____

Date: ____