Highland Dental

1604 Randolph Ave
St. Paul, MN 55105
Phone: (651)699-2113
Fax: (651)770-0428
Email: info@drmbrooks.com

I, __________________________, DOB, __________, do hereby authorize (previous

dental office name)______________________________________, to release my dental records (to include x-rays and/or written records) to the below-listed office:

Address to send records to:

Highland Dental
1604 Randolph Avenue
Saint Paul, MN 55105
(651)699-2113
Email: info@drmbrooks.com

*A photocopy of this authorization shall serve as an original.

Patient name (printed): ___________________

Patient Signature: ____________________________ Date: _____________