Release of Information

Full Name:_____

Email: _____

DOB: _____

Release of Information

☐ I authorize the release of information including the diagnosis, records & radiographs

Release of Information From:

Records may be released from:

Dental Office
Name:_____

Office Phone Number:_____

Office Email Address: _____

Please send these records to prairieplainsdental@outlook.com

Consent

Date: _____

Signature: _____

Prairie Plains Dental Dr. Patrick J. Capp 105 13th Ave E West Fargo, ND 58078

Phone: 701-282-7772 Email: prairieplainsdental@outlook.com