Dr. Jeffrey P Fish, DDS

MINNESOTA AUTHORIZATION FOR THE RELEASE OF DENTAL RECORDS

I hereby authorize _____, D.D.S. to release the information in the dental record of _____ (*Patient's Name*) to Dr. Jeffrey P Fish D.D.S., 107 West Main Street, Crosby, MN 56441, Phone: 218-546-6031, Fax: 218-546-8159.

The purpose of this release of health information is: _____

All information regarding my treatment in your office (a) between (*Dates*) _____

or (b) related to the specific procedure(s), treatment(s) or condition(s) (*Please List*) _____

_____

may be released including, but not limited to mental health records, drug or alcohol abuse records, which are protected by state or federal law, or HIV test results and related health care issues; if any, except as specifically provided by law.

_____

_____

OPTIONAL: I understand and agree to pay a reasonable charge to cover the cost of the transfer, as allowed by MN Statue 144.335, Subd. 5. Since the charges change annually, call the Department of health at 800-657-3793 or at 612-282-6314 for the most accurate amount.

This authorization is effective now and will remain in effect until _____ (no longer then one year). I understand that I may revoke this authorization before the year is over. I understand that I may receive a copy of this authorization.

Signature: _____ Date: _____

If not signed by the patient, please indicate relationship

- ❑ Parent or guardian of minor patient
- ❑ Guardian or conservator of an incompetent patient
- ❑ Beneficiary or personal representative of deceased patient

107 West Main Street — Crosby, MN 56441
Phone: 218-546-6031 — Fax: 218-546-8159 — eMail: info@jpfishdds.com