Dr. Jeffrey P Fish DDS * 107 West Main Street * Crosby, MN 56441 * 218/546-6031

MINNESOTA AUTHORIZATION FOR THE RELEASE OF DENTAL RECORDS

I hereby authorize ________________________________, DDS to release the information in the dental
(Prior Dentist/Dental Office)
record of __________________________ to Dr. Jeffrey P. Fish D.D.S., 107 W. Main Street, Crosby, MN
(patient's name)
56441, Phone: 218-546-5707, Fax: 218-546-8159.

The purpose of this release of health information is: ____

All information regarding my treatment in your office (check one)

- ❑ between dates _______________ to _______________ , or
  (start date) (end date)
- ❑ related to:
  - procedure - ____________________________________
  - treatment - ____________________________________
  - condition - ____________________________________
  - report - ____

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 below.

____

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 (date no longer then 1 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.

______________________________	______________________________
Patient's Name	**Date**
______________________________	______________________________
Signature* (person responsible for patient)	**Relationship, if not signed by the patient** (parent/guardian of minor, guardian/conservator of an incompetent patient, or beneficiary or personal representative of deceased patient)
______________________________	
Print Name* (person responsible for patient)	