Design Dentistry, LLC
7674 Design Road
Baxter, MN 56425
218-828-4816

Consent to share confidential Medical/Dental records

Patient Legal Name: ____

Date of Birth: ___________________________

I hereby authorize Design Dentistry, LLC to share:
Circle all that apply:

All Dental records Appointment times and dates Medications I'm taking

Lab results

Full Name: ____ Relationship: ________________

Full Name: ____ Relationship: ________________

Full Name: ____ Relationship: ________________

I understand that I may cancel this consent at anytime (by writing to Design Dentistry, LLC), but that canceling it will not affect any information that has already been released.

Signature: ____ Date: _____________

Relationship to minor patient (if parent or legal guardian) _______________________________