Patient Release of Dental Records Consent Form

Date:

Patient's Name:

Patient's Address:

Patient's Phone:

Please release my records to:

Prairie Dental Center
4904 South Minnesota Avenue
Sioux Falls, SD 57108
Dr. Justin Nichols
Dr. Mallory Cicmanec
Dr. Cassondra Braun Heinz
Business phone: (605)335-8640
Business Fax: (605)332-9956

Email: prairiedtl@gmail.com
Web: prairiedentalcenter.com

Patient's Signature: _____