



ELITE DENTAL, LLC

IMPLANT, COSMETIC, ORTHODONTIC, & SEDATION DENTISTRY

Records Release Request

Please complete and deliver (mail, fax, drop off, email) to your previous dentist if you would like any x-rays or records transferred to our practice.

I authorize the release of dental records and medical records relevant to dental treatment, or copies of such, and request they be transferred via mail or email to:

Elite Dental, LLC
1525 Livingston Ave., Suite B,
West St. Paul, MN 55118
Phone: 952-432-1716
Email: info@elitedentalllc.com

Patient: _____

Signature : _____

Date of Birth: _____

Date: _____

Dependents (under 18)

Date of Birth

