Children's Dental of Winona

Records Release Request

I give my consent to Children's Dental of Winona, LLC to release any pertinent records of the patient listed below.

Patients Name: _____ Patient's Birthdate: _____
Address:_____
City/State/Zip:_____

Please release records as indicated below:

□ To □ From Children's Dental of Winona
150 East 4th Street
Winona, MN 55987

□ To □ From _____
_____
_____

_____ _____
Signature (Legal Guardian) Date