Leipnitz Dental Clinic, S.C.
Release Form for Dental Records & Radiographs

I, __________________________ give permission to release copies of my

dental records and x-rays from ___________________________________

to Leipnitz Dental Clinic, S.C.

Signature of Patient or Guardian ***Date***

_______________________________________ _____________

Address of previous Dentist

Please send my records to:

Leipnitz Dental Clinic, S.C.
2521 South Broadway, Suite 1
Menomonie, WI 54751
info@leipnitzdental.com
715-235-7371 FAX 715-235-7380