



**carousel**  
PEDIATRIC DENTISTRY

15160 Foliage Ave Suite 110  
Apple Valley, MN 55124  
Phone: (952)-715-6177  
Fax: (952)-715-6178  
admin@carouselmn.com

### Dental Record Release Form

I, \_\_\_\_\_ hereby authorize:

Carousel Pediatric Dentistry & Orthodontics to release records for:

Patient name: \_\_\_\_\_

Patient name: \_\_\_\_\_

Patient name: \_\_\_\_\_

Patient name: \_\_\_\_\_

To be sent to:

Practice Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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Signature

Print

Date