



Chanhassen Family Dentistry, P.A.  
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### Voluntary Release of Information

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

At Chanhassen Family Dentistry, P.A., we are dedicated to protecting your right to privacy. That is why if you would like to authorize someone, such as a spouse, relative, or friend to help you with matters concerning your dental/medical records, we ask you to review, complete and sign below.

Note that the completion of this authorization is completely voluntary. This will allow us to release information about your dental health to the person(s) specified. Please remember, this concerns your personal records and the form can only be signed by you or by your legally authorized representative (such as a power of attorney, guardian or conservator).

Name of Person Authorized: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_  
(if signed by a personal representative of patient)