HEIDI BRANDENBURG
DDS

RECORD RELEASE

Patient Name: _____ Date of Birth:_____

Address:_____

I request and authorize all copies of any and all clinical records including previous FMX and Panorex within the last five years and BWX within the last two years to the following:

HEIDI BRANDENBURG, D.D.S.
3948 West 50 th Street, Suite 201
Edina, MN 55424
E-mail: frontdesk@hb-dds.com

Phone: 952-922-8787
Fax: 952-922-5595

Time and date of next appointment: _____

Signature: _____Date:_____

Relationship to patient: _____