CRYSTAL DENTAL CARE
5640 West Broadway • Crystal, MN 55428
(763) 537-3655

Date of request _____

My permission is granted to the office of _____

to disclose to Crystal Dental Care, complete information concerning the medical findings and treatment of _____
patient name

from _____ to _____
date date

I release Dr. Kimberlee Murphy from any laws related to disclosure of confidential or privileged information.

Signature _____ Date _____
patient or person authorized to consent for patient

Address _____