Brook West
Family Dentistry

I authorize the release of all current dental films and records to **Brook West Family Dentistry**. Please mail films or e-mail jpg format files to the following:

Brook West Family Dentistry
7950 Main St N
Suite 205
Maple Grove, MN 55369
Info@BrookWest.com (jpg file format only)

Printed Name:_____

Date:_____

My appointment at Brook West Family Dentistry is scheduled on:_____

If there are any questions, please contact me at: (phone #)_____

Thank you.

X_____
(Your Signature)

Give this form to your previous dental office and instruct them to send your records to Brook West as outlined above. Thank you!

David E. Domaas, DDS • John C. Smith DDS • Eric Wang DDS
David G. Klump DDS, MS • Abdollah Rahimi, DDS, MS
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