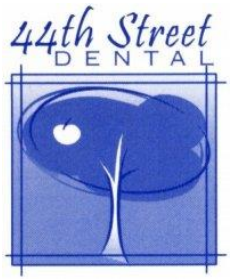

Authorization for Release of Dental Records

Name: _____ Date of Birth: _____

I hereby authorize the office below to release all radiographs and dental records related to my care:

Name of Previous Office: _____

Address/City/State/Zip: _____

Phone/FAX: _____

E-mail Address: _____

Please Send To:

44th St Dental
3925 W. 44th St
Edina, MN 55424
Info@44thstdental.com
Ph: 952-922-2159/ Fx: 952-922-3842

I also authorize the release of such records for my dependents listed below:

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Signature: _____ Date: _____