AUTHORIZATION TO RELEASE DENTAL RECORDS

To: _____
_____
Phone: _____
Address: _____
_____
_____
Patient: _____

I _____ hereby authorize your office to transfer the following records:

___ Radiographs (PA/BW/FMX/Panoramic)
___ Chart Notes
___ Treatment Records
___ Other

To: King Tooth
Address: 6100 Excelsior Boulevard, Suite East
St. Louis Park, Minnesota 55416
Web: www.kingtooth.com
Phone: (952) 929 4545
Fax: (952) 929 4592
E-mail: info@kingtooth.com

KING TOOTH

Signature: _____
Date: _____