



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

Signature: _____
Date: _____