TWIN CITIES DENTAL .com

X-Ray Release form

We are happy to help transfer your dental records. Simply, fill out the information below and fax or email it back to us.

Authorization of Release of Dental Records and X-rays.

I give consent to release x-rays from _____
On _____/_____/_____ (Clinic Name)
(Date)

Please list all included family members:

_____ DOB_____ _____ DOB _____
_____ DOB_____ _____ DOB _____

I would like to have my chart and x-rays sent to the following location via:

Clinic Name	
Address	Street:
	City: Zip: State:
Phone	
Fax	
Email	

-Or-

- Champlin Location: Twincitiesdental@hotmail.com (fax: 763-421-7916)
- Andover Location: Tcdandover@hotmail.com (fax:763-324-0790)

_____ _____
(Signature of Patient or Guardian of Patient) (Print Full name)