I, ____(DOB:_______________) hereby authorize
____ to transfer the following records:

___ Radiographs (PA/BW/FMX/Panoramic)

___ Chart Notes

___ Treatment Records

___ Other

Please include the following family members:

____DOB:____________

____DOB:____________

____DOB:____________

To: Cities Dental Studio
1421 Wayzata Boulevard East, Suite 303
Wayzata, MN 55391

Please send all digital records to info@twincitiesdentalstudio.com

Printed Name: ____

Signature: ____

Date: ____

1421 Wayzata Boulevard East – Suite 303 – Wayzata, MN 55391
P: (952) 746-7891 ♦ F: (952) 746-7892
info@twincitiesdentalstudio.com ♦ www.TwinCitiesDentalStudio.com