I, ____(DOB:______________) hereby authorize Cities Dental Studio 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: ____

____

Phone: ____

e-mail: ____

Printed Name: ____

Signature: ____

Date: ____

Please allow 5-7 business days to complete all transfer requests

There will be a $25 processing fee for all records other than most recent radiographs and clinical note

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