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: _____