WEST RANGE DENTAL CARE
1043 EAST HWY 169
PO BOX 339
GRAND RAPIDS, MN 55744

AUTHORIZATION FOR RELEASE OF DENTAL RECORDS AND X-RAYS

PATIENT NAME: _____DOB_____

PHONE NUMBER: _____

I hereby give permission to release any and all of my dental records to James D. Rostvold, D.D.S.

Please forward any **complete series** or **panoramic film** from the last 5 years or **Bitewing** x-rays from the last 2 years along with any other recent dental treatment information.

Please provide the date of patient last exam and cleaning. _____

_____ _____

Patient Signature (Parent if Minor) Date

If records are digital, please email to: info@westrangedental.com

Or mail to:

West Range Dental Care
PO Box 339
Grand Rapids, MN 55744