



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:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_

**PHONE NUMBER:** \_\_\_\_\_

**TRANSFER RECORDS FROM:** \_\_\_\_\_  
Name of Dentist Office Phone #

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. \_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature (Parent if Minor)

\_\_\_\_\_  
Date

If records are digital, please email to: [patients@westrangedental.com](mailto:patients@westrangedental.com)

Or mail to:

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