Date: _____

I authorize the release of any current radiographs from North Branch Dental, Dr. Geoffrey Archibald and Dr. Eric Youngner to:

_____

_____

_____

Reason for Transfer: _____

_____

Print Name of Patient: _____ DOB:_____

Signature of Patient or Legal Guardian: _____

Please drop off, mail, e-mail or fax this form to:

6460 Main Street
P.O. Box 220
North Branch, MN 55056

mail@northbranchdental.com

651-203-7373 (fax)