

RELEASE AUTHORIZATION

To: _____

Phone: _____

Patient: _____

Address: _____

Phone: _____ Birthdate: _____

I request that you send the following records:

- All previous radiographs, regardless of age (Prefer originals rather than duplicates)
- Radiographs only on teeth # _____
- Copy of all treatment notes
- Copy of treatment notes regarding only teeth # _____
- Other:

TO:

Ronald L. King, DDS
6100 Excelsior Blvd, Suite East
St. Louis Park, MN 55416
Phone: 952-929-4545
FAX: 952-929-4592

REASON:

- Changing offices
- Second opinion/Consultation

Patient Signature: _____

Date: _____