I authorize:

____

(Name of Dental Office)

____

(Address)

____

(City, state and zip code)

____

(Phone number) (Fax number)

To release my xrays/records to:

Commerce Drive Dental Group

2040 Commerce Drive

North Mankato, MN 56003

(507) 345-7786

cddental@commercedrivedental.com

Signature:______________________________ Date:______________

Print Name:_____________________________ Date of Birth____________

Patient's Name:__________________________ Date of Birth____________

Please forward x-rays, perio charting and any unfinished treatment.

2040 Commerce Drive, North Mankato, MN 56003 507.345.7786 tel 507.345.3445 fax cddental@commercedrivedental.com
www.commercedrivedental.com