Authorization and Request for release of dental radiographs:

___ Bitewings (within last 12 months)

___ Full mouth Xrays or Panorex (within last 3 to 5 years)

Please forward my current x-rays to:

Tangletown Dental
4831 Nicollet Ave S
Minneapolis, MN 55419

Patient Name: _____

Date of Birth:_____ Phone Number: _____

Address:_____

Patient Signature:_____ Date:_____