

# Northern Lights Dental

Patient Name: \_\_\_\_\_

Date: of Birth: \_\_\_\_\_

I authorize Northern Lights Dental to release my dental records and xrays to the following office:

Office Name: \_\_\_\_\_

Office Email: \_\_\_\_\_

Office Phone: \_\_\_\_\_

Office Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_