I hereby authorize the release of my x-rays and/or records from:

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

To:

High Plains Dental, PC
669 12th St. W
Dickinson, ND 58601

Phone – (701) 483-4746
Fax – (701) 483-2273
Email Address: info@highplainsdentalpc.com

Patient Name: _____

Date of birth: _____

Signature: _____

Parent/Guardian Name: _____

Date: _____