Patient Authorization

I hereby authorize employees of the Dental/Medical clinic listed below:

_____ _____
Clinic Name Phone Number

To release the following health information about myself and/or family members listed:

_____ _____ _____

_____ _____ _____
(Please print all patient names)

Please forward all indicated information:

_____ Full Mouth Series, Panorex & Bitewing X-rays

_____ Complete Treatment Notes

_____ Complete Periodontal Charting

_____ Other (describe): _____

_____

_____

The health information described above may be used by and released to:

saluté DENTAL
family & cosmetic dentistry
2101 Woodwinds Drive
Suite # 500
Woodbury, MN 55125

This Authorization expires when the above information is received by Saluté Dental.

_____ _____
(Patient/Parent/Legal Guardian Signature) (Date)