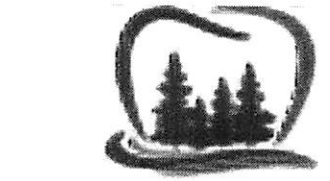

Date: _____

I authorize the release of any current radiographs from Forest Lake Smiles, Dr. Jon Siverson to:

_____

_____

_____

Reason for Transfer: _____

_____

Print Name of Patient: _____

Signature of Patient or Legal Guardian: _____

Please drop off, mail, e-mail or fax this form to:

1068 Lake Street South
Suite 210
Forest Lake, MN 55025
mail@ForestLakeSmiles.com

651-464-0133(fax)