Date: _____

I authorize the release of any current radiographs from the office or doctor named below to North Branch Dental, Dr. Geoffrey Archibald, Dr. Eric Youngner, Dr. Kyle Merrick and Dr. Lisa Domeyer.

_____

_____

_____

Print Name of Patient: _____ DOB: _____

Signature of Patient or Legal Guardian: _____

Please mail or e-mail radiographs to:

6460 Main Street
P.O. Box 220
North Branch, MN 55056

mail@northbranchdental.com