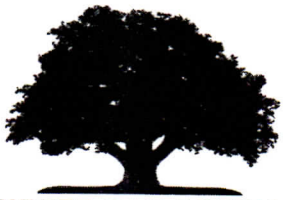

RECORDS RELEASE

I hereby authorize (office name): _____

Address: _____ Phone: _____

_____ Email: _____

To furnish the records in your possession concerning my condition and/or treatment. Including current radiographs and any pertinent dental information to WHITE OAK DENTAL.

Patient(s) name & DOB: _____

_____

_____

Signature: _____ Date: _____

admin@whiteoakdentalmn.com

Phone: 218-346-7700 Fax: 218-346-5230

135 3rd St NE, Perham, MN 56573