Advanced Dental
608 East Madison Avenue
Mankato, MN 56001
(507) 345-1284
info@advanceddentalmn.com

I, _____ , authorize the release of dental x-rays to/from Advanced Dental to above stated email address.

_____
Patient Name & Date of Birth:

_____
Patient Signature or Guardian

_____
Date

This authorization is valid for one year unless I indicate an earlier date here :

Date ___/___/___