Bayview DENTAL

Date: _____

I authorize the release of any current radiographs between the following offices:

Bayview Dental
420 Grand Ave
Center City, MN 55012
mail@bayviewdentalmn.com

Information for other dental practice:

Office Name: _____

Address: _____

Email: _____ Phone: _____

Reason for Transfer: _____

Print Name of Patient: _____

Signature of Patient or Legal Guardian: _____

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

420 Grand Ave
P.O Box 235
Center City, MN 55012
mail@bayviewdentalmn.com
651-257-1094 (fax)