Twin Cities SEDATION

Date: _____

I authorize the release of any current radiographs from the office or doctor named below to Geoffrey Archibald, DDS and Twin Cities Sedation Dental.

_____

_____

_____

Print Name of Patient: _____

Signature of Patient or Legal Guardian: _____

Please mail or e-mail radiographs to:
808 Broadway Ave W
Suite A
Forest Lake, MN 55025

mail@TwinCitiesSedation.com