Authorization for Release of Dental Records

Date: _____

I Hereby Authorize:

To Furnish All Radiographs and Dental Information to the Care of:

Dr. Luke W Bogdanowicz & Associates LTD
8525 Edinbrook Crossing, Suite 402
Brooklyn Park, MN 55443
Phone: (763) 425-5277
Fax: (763) 315-4977
drlukesdental@gmail.com

Print Name: _____

Signature: _____

Relationship: _____

Dr. Luke W Bogdanowicz & Associates LTD

8525 Edinbrook Crossing Suite 402, Brooklyn Park, MN 55443
Phone: (763) 425-5277 Fax: (763) 315-4977

X-Ray Release

We're happy to release your x-rays from our office. Simply fill out the information below and either fax or email it back to us.

_____ gives consent to have my chart and
(Patient's full legal name)

x-rays released from Dr. Luke W Bogdanowicz & Assoc. LTD on _____/_____/_____
(Date)

I would like to have my chart and x-rays sent to the following location:

Clinic Name: _____

Address: Street: _____

City:_____ Zip: _____State: _____

Phone: _____

Fax: _____

Email: _____

_____ _____
(Signature of Patient or Guardian of Patient) (Print Full Name)