**Authorization for Release of Dental Records to Northwoods Dental**

I, ____________________________________________, hereby give permission to Northwoods Dental to receive a copy of my current radiographs (full mouth series, bitewings, and/or periapicals).

**Northwoods Dental prefers digital x-rays. Please email images to:** info@northwoodsdental.com

If unable to email digital x-ray images please send to the address listed below:
Northwoods Dental
15600 36th Ave N #270
Plymouth, MN 55446
763-557-0911

Patient/Guardian Signature: ________________________________________________________

Date: ______________________________________