PATIENT AUTHORIZATION FOR RELEASE OF X-RAYS AND TREATMENT INFORMATION

TODAY'S DATE _____

PATIENT'S NAME(S) _____

_____

PLEASE RELEASE MY X-RAYS AND TREATMENT INFORMATION TO:

PIKE LAKE DENTAL CENTER
MATTHEW D. JUGOVICH, D.D.S.
MEAGHAN MORRELL-HUOT D.D.S.

5651 MILLER TRUNK HIGHWAY
DULUTH, MN 55811
(218) 729-7270
PIKELAKEDENTAL@GMAIL.COM

SIGNATURE OF PATIENT OR PARENT/GUARDIAN _____

RELATIONSHIP TO PATIENT, IF PATIENT IS A MINOR _____

PIKE LAKE
DENTAL CENTER