I, ________________________________, hereby authorize the release of dental x-rays and dental records for myself and the following family members.

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Please forward to: **Smile Eden Prairie**
6600 City West Parkway #315
Eden Prairie, MN 55344
contactus@smileedenprairie.com

Patient Signature____ Date_______________

If there are any questions or if there are no current records available, please contact Smile Eden Prairie at 952-941-9829. Thank you!