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

Please forward to: **Cherrywood Dental Care**
14127 Vernon Avenue South
Savage, MN 55378
contactus@cherrywooddental.com

Patient Signature _____ Date _____

If there are any questions or if there are no current records available, please contact
Cherrywood Dental Care at 952-440-9303. Thank you!