BROOKSIDE
DENTISTRY

Luke A. Foster, DDS
Chia-Yin Lo, DDS

Authorization for Release of Dental Records to Brookside Dentistry

Patient Name ____ Date of Birth _________________

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I authorize the release of my dental records (including radiographs) to:

Dr. Luke Foster
Brookside Dentistry
4047 Brookside Avenue
St. Louis Park, MN 55416

info@brookside-dentistry.com

Phone: (952) 924-0709
Fax: (952) 746-3329

Name of previous dentist/dental office ____

Address and Phone (if known) ____

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Signature of Patient, Parent, or Guardian ____ Date____________________

Dental office please note:

- Please include most recent bitewings and full mouth series (dated) - Thank you.