



Authorization for Release of Dental Records to Brookside Dentistry

Patient Name _____ Date of Birth _____

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) _____

Signature of Patient, Parent, or Guardian _____ **Date** _____

Dental office please note:

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