RECORD RELEASE AUTHORITY

Date: _____

To: _____

Address: _____

City: _____ State: ____ Zip Code: _____

I hereby authorize the release of my dental records or copies of such and request that they be transferred to:

Nord Dental Center
1404 Eastland Drive, Suite 102
Bloomington, IL 61701
309.663.9421
Email: Nordmilligandentalcenter@gmail.com

_____ _____

Print name of patient Signature of patient