Port Credit Dental

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RADIOGRAPH & RECORDS RELEASE

Date:

Name of Previous Dentist: **Phone #:**

Fax #:

I hereby authorize you to release all radiographs and dental information for:

_____
(Patient's Name, please print)

Please send x-rays with dates in the filename and also include date of last complete oral exam, hygiene & recall exam. Please also include any specialist/biopsy reports.

Forward the info to:

Mail:

Port Credit Dental
224 Lakeshore Rd. West, Unit 6
Mississauga, Ontario
L5H 1G6

Or e-mail:

info@portcreditdental.com

Thank you.

_____
Patient Signature