AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

Name and Number of Previous Dentist: _____

Patients Name/s: _____

Address: _____
_____
_____

I hereby authorize you to transfer my dental records and
any x-rays within the last three years to:

Beamsville Smiles
4413 Ontario St., Suite 203
Beamsville, ON
L3J 0AY
Or:
info@beamsvillesmiles.ca

For Office Use Only

Last Recall:_____
Last BW's:_____
Last NPE:_____
Last FMS:_____
Last Panorex:_____

Thank you for your co-operation with this matter.

Signature: _____

Date: _____