Patient Record & Radiograph Release Form

I_____________________________, authorize and request that my records and radiographs be released and transferred to the doctor at North Star Dentistry at the address below:

714 Lakeshore Rd. East, Unit #5
Mississauga, Ontario
L5G1J6

Office Number: 905-274-0442
Fax Number: 905-274-6583
e-mail: info@northstardentistry.ca

Patient Name (s): __________________________________ __________________________________

__________________________________ __________________________________

Date of last exam: ___________________________

Bitewings: ___________________________

F. M. S.: ___________________________

Panorex: ___________________________

Date of new patient exam: ___________________________

Patient Name: ______________________ Doctor's name: ____________________

Patient signature: ____________________ Doctor's signature: _________________

Today's date: _______________________