Clyde Dental Centre

Authorization for Release of Dental Records and Radiographs

Dear Doctor,

I _____ hereby authorize the release of my / my family's dental radiographs from the office of _____, to **Clyde Dental Centre**.

In addition, please also include any additional information that would be beneficial to my dental care.

Please forward at your earliest opportunity to ensure no interruption in my dental care.

Date: _____

Patient signature: _____

Family member's names also transferring to **Clyde Dental Centre**: _____

_____

- **Date of last Bitewings:** _____
- **Date of last Panorex or Full Mouth Series:** _____
- **Date of last Recall Exam:** _____
- **Date of last New Patient Exam:** _____

Kindly provide bws within last two years and panorex within last five years only.

Thank you.

Send via email to: info@clydedentalcentre.ca

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