Dental Radiograph Release Form

This form is to authorize the release of dental radiographs for the following:

I, ______________________________, would like to thank you for the dental care you have provided and ask that in order to preserve the continuity of care, please forward any clinical records and all radiographs to Blatt Family Dentistry.

Previous Dental Office: ________________Dentist Name: DR. _______________

Office Phone Number: ____________________________________

In order to ensure best optimal care, please also provide dates for the following information:

Date of last Complete Exam	01103	_____________________
Date of last Recare examination	01202	_____________________
Date of last Panoramic Radiograph	02601	_____________________
Date of last Bitewings	02142	_____________________
Date of Full Mouth Series	02102	_____________________

All current radiographs can be emailed to drblatt@bellnet.ca or mailed to
Blatt Family Dentistry
1244 King St W
Toronto, ON M6K 1G5

I, ______________________ have given consent for the disclosure of this information and I request that my records be released.

__________________________ ___________________________

Signature of Patient (or Guardian) Date