2768 Laurier St., P.O. Box 197
Rockland, ON, K4K 1N4
613-446-0009 (T) 613-446-8811 (F)
info@dentistryatrockland.ca

By this note, I/we, ______________________________________________________________

date of birth: ________________________________________________________________,

hereby authorize Dr. _________________________ from _________________________________,

☎ ___________________________ 🖶 _____________________________.

to release my/our following dental records:

To Dr. __________________________, at the postal address, fax or email noted above.

***Dates and copies of my last:***

NP Exam (01101-01102-01103) _____________________________________________________

Scaling __________________________________________________________________________

Bw's _____________________________________________________________________________

PAN ______________________________________________________________________________

Patient signature: ___________________________________ Date: _______________________

Witness signature: ___________________________________ Date: _______________________

Thank you kindly,