Limeridge Mall Dental
999 Upper Wentworth St
Hamilton, ON
L9A 4X5

Release of Dental Records

Dear Dr. ____
(former dentist)

I hereby authorize the release of my / my family's dental radiographs to Limeridge Mall Dental. Please note the date of my last recall and any additional information that would be beneficial to my dental care. Thank you for forwarding my records at your earliest convenience.

Last COE: ____

Last Recall: ______________________________________

Last BW: ____

Last Panorex: ____________________________________

Last PA: ____

<u>Release Records To:</u>
Limeridge Mall Dental
Phone: (905) 575-0412
Fax: (905) 575-5860
limeridgedental@rogers.com

Patient Name: ____

Patient Signature: ____

Date: ____