



29 Main St. W., Suite 100 Beeton, Ontario L0G 1A0
Phone (905) 729-7272
info@beetonfamilydentalcentre.com

Authorization For Release Of Dental Records

To: Dr. _____

Address: _____

City: _____

Phone Number: _____

Fax Number: _____

I hereby authorize you to transfer my / our dental records and associated radiographs to the office of Dr. Rosanna Porretta and associates

Kindly provide the following information:

Date of initial examination: _____

Last recall examination: _____

Last scaling / polishing: _____

Last BW's, Panorex, FMS: _____

Any other pertinent information they may require including pending treatment, etc.

Thank you for your co-operation in this matter.

Patient Name(s): _____

Signature: _____

Date: _____