Authorization to Release Records to Innisfail Family Dental

4935 50 St, Box 6166
Innisfail, AB T4G 1S8
tel: 403.227.6666
fax: 403.227.6494
info@innisfaildental.ca

Date_____

Dear Dr/Clinic_____

Patient Name{s} _____

We request the release of the following dental information on behalf of the above mentioned patient{s}.

Duplicate(s) of radiographs taken within the last two years:
( )B/W
( )PA
******Include date Xrays were taken******

Duplicates(s) of radiographs taken within the last five years:
( )PAN
( )Full mouth series
******Include date Xrays were taken******

Other_____

I hereby authorize the release of any pertinent dental information and or radiographs to the care of Innisfail Family Dental.

_____
Patient Signature or Legal Guardian

Address_____

City/Postal Code_____

Phone Number_____