

X-RAY RELEASE FORM

Today's Date: _____

Dentist from whom you are requesting x-rays: _____

Dr. _____

Phone #: _____

Fax #: _____

I hereby authorize you to release all dental radiographs for the following patient. Please provide the following information to help develop our treatment plan:

PATIENT NAME	DATE OF BIRTH (MM/DD/YY)	NEW PATIENT EXAM IN YOUR OFFICE (MM/DD/YY)	LAST VISIT IN YOUR OFFICE (MM/DD/YY)	LAST RECALL EXAM IN YOUR OFFICE (MM/DD/YY)	LAST ORAL HYGIENE IN YOUR OFFICE (MM/DD/YY)	LAST RADIOGRAPHS (MM/DD/YY)

Thank you in advance for providing this information.

Please forward x-rays and this completed form to Diamond Dental Centre by:

- E-mail: info@diamonddentalcentre.com with subject line **ATTN:Vaughan Office--Dental Documents for (Patient Name)**

OR

- Mail: Diamond Dental Centre
1801 Rutherford Road, Unit A1
Concord, ON L4K 5R7

Signature: _____ Print: _____