

# Cedar Springs Dental Office

Dr. Elizabeth Vella Caruana

419 Dundas Street East, Suite 7

Waterdown, Ontario

L0R 2H1

Phone (905) 690-4040

Fax (905) 690-6060

## Authorization for the Release of Radiographs and Dental Records

I hereby authorize

Doctor \_\_\_\_\_, to

(Name of your previous Dentist)

Release Dental Radiographs and Dental Records

\_\_\_\_\_ (patient's name)

To: Dr. Elizabeth Vella Caruana

419 Dundas Street East, Suite 7

Waterdown, Ontario

L0R 2H1

Name : \_\_\_\_\_ (please print)

Signed : \_\_\_\_\_ Date : \_\_\_\_\_

**If not signed by the patient, please indicate relationship:**

- parent or guardian of minor patient
- guardian of patient
- executor of beneficiary of deceased patient

Date of the following:

Last Complete Exam: \_\_\_\_\_

Full Mouth Series: \_\_\_\_\_

Panoramic: \_\_\_\_\_

Cleaning: \_\_\_\_\_

Recall: \_\_\_\_\_