One Centre Dentistry

To:
Dr.________________________Tel:___________________Fax:_______________

I____hereby request and authorize the release of

__my __my family's

dental records and radiographs/digital x-rays to **ONE CENTRE DENTISTRY** at the below address.

Dental records to be transferred on my behalf should include:

__a summary of all information pertinent to prior treatment, including treatment record and periodontal probing record (photocopies are acceptable)

__ copies of original radiographs from the most recent full mouth series, panoramic films, and all films taken within the last 24 months.

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Patient Signature Date

69 Lebovic Ave. Suite 213, Toronto, Ontario, M1L0H2
t: 416.445.2919 f: 416.445.2865 e: info@onecentredentistry.com w: onecentredentistry.com