Address: 7 William Graham Dr. Unit A1 Aurora, Ontario L4G 0V7
Phone: (905) 727-1717 | **Fax:** (905) 727-7070 | **Email:** info@stjohnsdental.ca

Date: ______________________

The Following Patients:

1.____________________________________ 4.___________________________________

2.____________________________________ 5.___________________________________

3.____________________________________ 6.___________________________________

Authorize the release of records, x-rays and any other pertinent information from

____
(Name of Previous Dental Office)

To my new Dental Office whose name and address appears above.

Signature: __________________________________

Please provide the following information for each person (s).

Name & date	Complete Exam	Recall Exam	Full Mouth Series	Panorex	BWs

Please send response back via fax and copies of digital radiographs can be emailed.

Thank you kindly,
St. John's Family Dentistry Staff