476 Cataraqui Woods Dr. Kingston, Ontario K7P 0J4 613-384-4224
www.cataraquidental.com

Release of Records Form

Date_____

Dr. _____
(Dentist from whom you are requesting x-rays)

I hereby authorize you to release all dental radiographs for:

_____
(Full Name)

(Date of Birth)

Please forward chart records to:

Cataraqui Dental Centre
476 Cataraqui Woods Drive
Kingston, Ontario
K7P 0J4
613-384-4224
613-384-4337

reception@cataraquidental.com

Signature: _____
(patient, parent, guardian)