**870 Queenston Blvd**
**Woodstock, ON N4T 0M4**
**T: 519 537 3444**
**F: 519 537 2134**
**E: info@woodstockdentist.ca**

## Release of Records and Radiographs Consent Form

Attention: ____________________________________________

Phone: ______________________ Fax: ______________________

E-mail: ____________________________________________

Patient(s):

1. ______________________ Date of Birth: ______________
2. ______________________ Date of Birth: ______________

The above patient(s) authorize North Woodstock Dentistry to receive all records and radiographs that you have on file. Please mail/e-mail them to our office, as well as fill in the information below. We appreciate your help!

**Patient 1:**

NPE/Mixed/Primary Exam:

______________________

Recall, Polish and Fluoride:

______________________

Bitewings and PA's:

______________________

PAN and FMX:

______________________

Scaling Units used per benefit year: __________

**Patient 2:**

NPE/Mixed/Primary Exam:

______________________

Recall, Polish and Fluoride:

______________________

Bitewings and PA's:

______________________

PAN and FMX:

______________________

Scaling Units used per benefit year: __________

______________________
Signature

______________________
Date