CONSENT FOR RELEASE OF X-RAYS

Please fill out the form below if you are coming to our office and would like for us to obtain x-ray records from a different office where you have been a patient. Please return the form to us via fax, mail, or e-mail prior to your appointment so that we may have time to obtain your records from your previous dentist before seeing you at our office.

Previous Office:	

Patient Name(s) & Date(s) of Birth	(1)
	(2)
	(3)
	(4)

I authorize and request that copies of my dental x-rays and associated information be released to:

Chapel Hill Dental
3400 ch. Innes Rd., Orléans, ON K1W 0G1
Tel.: 613.424.4241 Fax: 613.424.8887
Email: smile@chapelhilldental.ca

Patient/Guardian Signature:	
Date:	

TO BE COMPLETED BY THE COOPERATING OFFICE
Please provide the following additional information regarding the above-mentioned patient:

Date of last Complete Exam:	
Date of last Recall Exam:	
Date of last Panoramic Radiograph:	
Date of last Bite Wings:	