smilee
DENTAL CENTRE

Date: ______________________________

To: ____
____

From: ____
____

I hereby authorize the immediate release of all recent dental radiographs taken of me by your office to:

Dr. Andrew Lee
52 Front Street South
Thorold, ON
L2V 1W9

X-Rays in the last 36 months Date: ______________________________
Last complete examination Date: ______________________________
Last recall / perio scaling Date: ______________________________
Last panorex x-ray Date: ______________________________

____
Patient Signature

____
Date

52 Front St S, Thorold, ON L2V 1W9
905 227 0303 905 227 0300
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info@smileedental.ca