

BRANT SMILES FAMILY DENTISTRY
415 FAIRVIEW DRIVE, UNIT A
BRANTFORD, ON N3R 7M3

p. 519-759-0011 / f. 519-759-8392
e. office@brantsmiles.ca

To the office of _____

At the request of mutual patient _____,
we ask that you kindly forward the following records to our office by email as per
the address as noted above:

_____ PANOREX, dated _____

_____ BITEWINGS, dated _____

_____ DATE OF LAST NPE/COE _____

_____ DATE OF LAST RECALL EXAM _____

I hereby authorize the release and request the transfer of the above records to
Brant Smiles Family Dentistry, on my behalf.

Patient Signature

Date

Witness Signature

Date