120 Terence Matthews
Kanata, ON K2M 1P7
(613) 519-1400
info@kanatasouthdental.com

Authorization for Release of Dental Records and Radiographs

Previous office:_ _____

Phone : _____

I _____hereby authorize the release of my / my family's dental radiographs to Kanata South Dental.

In addition, please note date of last complete exam and any additional information that would be beneficial to my dental care. Please forward at your earliest convenience.

Date :_____

**Patient Signature _____

Date of new patient exam _____

Date of last Panorex:_____

Date of last bitewings:_____

Date of last polish/fluoride:_____

Thank You.
Kanata South Dental team