ST. MARYS DENTISTRY

Information Release

To: _____

RE: _____

I authorize you to furnish copies of the most recent radiographs (bitewings/pan/periapical/full mouth series) taken with the last 5 years.

Kindly provide the following:

Intial Examination (01101/2/3)

Last Recall Examination (01202)

Last Scaling/Polishing (11101, 11111)

Any other pertinent information

Please forward records to the office of:

Dr. Michael Nixon

520 Water St. S

Box 1650

St. Marys, ON N4X 1B9

Phone: 519-284-2660

Fax: 519-518-3035

Email: info@stmarysdentalclinic.com

I release you from all legal responsibility or liability that may arise from this authorization.

Signature: _____

Dated: _____

Place: _____

Witness: _____