PINE STREET DENTAL

Date: _____

To: _____
_____

From: _____
_____

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

Dr. Andrew Lee
9 Pine St. N, #33
Thorold, ON
L2V 3Z9

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

9 Pine Street North Unit # 33, Thorold. ON L2V 3Z9
905 227 0303 905 227 5358
pinestreetdental.ca
info@pinestreetdental.ca