STRATFORD DENTAL
DR. MARK STRAUS, D.D.S.

Authorization for the Release of Radiographs and Dental Records

Date: _____

Dear Dr. _____,
(Name of previous Dentist)

I, _____ hereby authorize the release of my dental radiographs and any pertinent information regarding previous dental treatment. Please forward them to:

Dr. Mark Straus, DDS
Stratford Dental
3035 Ontario St - Unit 101
Stratford ON
N5A 6S5
Email: info@stratforddental.ca

Please include dates for the following (to be filled out by previous dentist):

Last New Patient Exam: _____

Last Recall exam: _____

Last Bitewing x-rays: _____

Last Panorex x-ray: _____

Patient/Parent/Guardian Signature: _____

Thank you,

Stratford Dental