Dr. Heather Stone and Associates
Tel: 519-746-6447 Fax: 519-746-4924
Email: laurelwood.dentistry@gmail.com

Dental Record Release Form

Dear Dr. _____

The following patient(s) have recently transferred to our office:

_____ _____

_____ _____

_____ _____

Please email the following information and radiographs to the email address above.

Date of last New Patient Exam/Complete Exam: _____

Date of last Recall: _____

Date of last Scale: _____

Date of last Panorex: _____

Date of last BWs: _____

I, _____, hereby authorize the release of my (our) dental records and radiographs to Laurelwood Family Dentistry.

_____ _____

Patient Signature Date