Northern Lakes Dental
60 Champlain Street, Suite 201
North Bay, ON P1B 7M4
P: 405-472-5300
E: smile@northernlakesdental.com

Authorization for Release of Dental Records and Radiographs

I _____ hereby authorize the release of my / my family's dental radiographs to Northern Lakes Dental. In addition please note date of last recall and any additional information that would be beneficial to my dental care. Please forward at your earliest convenience.

Date _____

Patient Signature _____

Date of last recall or new patient exam _____

Please provide copy of clinical notes.

Thank You.