Dental Office Name: _____
Telephone #: _____
Fax #: _____

Please Mail x-rays to:
Avalon Dental Care
910 Dundas St. W
Whitby, ON L1P 1P7
Telephone: (905) 665-2353
Fax : (905) 665-2359
Email: dentalcare.avalon@gmail.com

Record of Release Form

I. _____ (parent, guardian or self), authorize Avalon Dental Care to receive a copy of the following chart(s) and current radiographs:

1.) _____
2.) _____
3.) _____
4.) _____
5.) _____

Thank you for your assistance.

Patient Signature _____

Date: _____