Meadowbrook Dental Centre
542 Armstrong Rd.
Kingston, ON K7M 7N8

Phone: *613-546-6865* ***Fax:*** *613-542-9511*

Authorization for Release of Information

I, _______________________________, hereby release all radiographs and dental records on file from the office of Dr. _______________________ to Meadowbrook Dental Centre.

Patient's Signature: ____________________________________

Patient's Name (Printed): _______________________________

Date: ____

To Be Completed by Dentist:

- Date of last Bitewings: _____________________________
- Date of last Panorex: _____________________________
- Date of Last Complete Oral Exam: ___________________

Please e-mail digital radiographs to:
accounts@mbdc.info
OR
reception@mbdc.info