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 x-rays/records on file from _____ to Meadowbrook Dental Centre.

Patient's Signature: _____

Patient's Full Name: _____

Date: _____

To Be Completed by Dentist:

Date of last Bitewings: _____

Date of last Panorex: _____

Date of last Complete Oral Exam: _____

I release you from all legal responsibility or liability that may arise for this authorization.
"Transmitted by email/courier/registered mail/ hand"

Please e-mail digital radiographs to:

booking@mbdc.info