



Laurelwood Family Dentistry  
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Fax: 519-746-4924  
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Previous Doctor/ Clinic Name \_\_\_\_\_

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I, \_\_\_\_\_ authorize any dental records, information and radiographs taken within the past 2 years of the name(s) listed below to be forwarded to the above e-mail address.

Please indicate the date of the most current Bitewings, Panorex as well as previous Recall/Scale date.

I authorize the information to be released for the following family members as well:

1. \_\_\_\_\_

4. \_\_\_\_\_

2. \_\_\_\_\_

5. \_\_\_\_\_

3. \_\_\_\_\_

6. \_\_\_\_\_

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Date: \_\_\_\_\_

Signature: \_\_\_\_\_