Kmadental Centre

800 Princess Street Suite#306
Kingston, ON K7L 5E4

Phone: 613-548-7963 ***Fax: 613-548-7348***

Authorization for Release of Information

I, ________________________________, hereby release all radiographs and dental

records on file from the office of

Dr.____to KMADENTAL.

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:

kobilovdds@gmail.com