ARCHER DENTAL

Advancing dental care in our changing world

XRAY RELEASE REQUEST

Previous Dentist Name _____
Previous Dentist Email _____
Previous Dentist Number _____

I, _____ would like to thank you for the dental care you have provided. I ask that in order to preserve the continuity of care that you forward all current radiographs & clinical records to **info@archerdental.ca**

Please provide the dates of the following information to ensure optimal care:

01103 _____
01202 _____
02601 _____
02142 _____
Scale _____
FMS _____

I have given consent for the disclosure of this information and I request that my records be released.

Thankyou for your timely response

_____

Patient Signature