To Whom It May Concern:

I, ______________________________, hereby release all radiographs and dental records on file from the office of Dr. ______________________________ to Dr. Robert Axelrad and Associates. Please forward a copy of dental treatment records, radiographs and any other information which may be pertinent to their treatment.

- Date of last Bitewings ___________________________
- Date of last Panorex or Full Mouth Series ___________________________
- Please include the date of the last Complete Oral Exam ___________________________

Patient's Signature: _____________________________

Patient's Name (Printed): ___________________________

Please mail records and radiographs to:

Dr. Robert Axelrad and Associates
40 Finchgate Blvd.
Suite 121
Brampton, Ontario, L6T 3J1

Digital Records can be sent to:
draxelrad@gmail.com