dentistryinajax

INFORMED CONSENT: X-RAY/PATIENT FILE RELEASE FORM

I _____ have elected to have all my dental records (including dental x-rays, patient chart, and diagnostic study models) sent to:


Dentistry in Ajax
300 Rossland Rd E, Unit 100
Ajax ON, L1Z 0M1
Tel: 905-427-5553
Fax: 905-427-5554
Email: info@dentistryinajax.com


**From:** Dr. _____

Tel: _____

Fax: _____

**Signature**:_____

**Date Signed**:_____

**Witness**:_____

**Date Faxed**:_____

Please include dates of previous treatment:

| | |
|---|---|
| COE | RC |
| FMS/PAN | POL |
| BW | SC |
| PA | FL |