Dr. Jennifer Thomm

1323 Michigan Ave., Unit B
Sarnia, ON N7S 4M6
P: 519.542.3427
F: 519.542.8222
info@greatlakesdental.ca
www.greatlakesdental.ca

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Dear Dr. ____

Re: ____
(print name of patient requesting transfer of records)

Thank-you for the care you have shown the above patient(s) in the past. In order to provide them with the same level of continuing care, we would appreciate if you would forward their most recent radiographs that you may have on file.

Thank-you in advance for your time.

I, ____ hereby authorize the release of the dental records as requested.
(print your name or parent/guardian's name)

____ _________________________________
Signature (patient or parent/guardian) Date

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OFFICE USE ONLY

Last Complete Exam Date: ____

Last Recall Exam & Cleaning: ____

Last Scale & Prophy: ____

Last Bitewing and PA X-Rays: ____

Last Panorex: ____