



grover
DENTAL CARE
Smiles "R" uss

RADIOGRAPH RELEASE FORM

Date: _____

Patient Name: _____

I, _____, authorize Dr. _____ to release Radiographs and/ or records to Grover Dental Care as I am now a patient of their practice.

The Radiographs are for: Myself

My children _____

Thank you for your prompt attention to this request.

Signature of Patient _____

11 Rebecca Street

Hamilton, Ontario L8R 3H7

Tel: (905) 521-2181 Fax: (905) 521-1645 rebecca@groverdentalcare.com
