Dentistry
on Sheppard

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Patient's Name/s: ______________________

Date of Birth: ______________________

This is to authorize Dr. ________________ to furnish copies of my radiographs and dental records to be sent to Dr. Mark Cloth.
Kindly include the following informations:

Date of last new patient exam:
Date of last full mouth/panoramic x-rays:
Date of last bitewing x-tays:

I release you from any legal liability or responsibility that may arise from this authorization.

Patient's Signature: ______________________

Dated: ______________________