CAMBRIDGE SMILES FAMILY DENTISTRY
410 HESPELER ROAD, UNIT 5
CAMBRIDGE, ON N1R 6J6

p. 519-622-1230 / f. 519-622-7232
e. office@cambridgesmiles.ca

To the office of ____

At the request of mutual patient______________________________________,
we ask that you kindly forward the following records to our office by email as per the address as noted above:

_____ PANOREX, dated _______________________________

_____ BITEWINGS, dated _________________________

_____ DATE OF LAST NPE/COE _____________________

_____DATE OF LAST RECALL EXAM __________________

I hereby authorize the release and request the transfer of the above records to *Cambridge Smiles Family Dentistry*, on my behalf.

______________________________	____________________________
Patient Signature	Date
______________________________	____________________________
Witness Signature	Date