

**Dr. Bruce, Walden & Hoben
Dental Office
277 Lambton St.
Kincardine, Ontario
N2Z 2Y6
519-396-2641
519-396-3999 (f)**



Radiograph & Information Release Form

To: Dr. _____

Fax: _____

Re: _____

Please release your most recent radiographs (bitewings, periapicals, panorex, full mouth series to our office.

Kindly provide the following information

- Initial Examination (01101/01102/01103)
- Last Recall Examination (01202)
- Last Scaling/Polishing (11111/11101/11107)
- Any other pertinent information

Please forward records to the office of:

Dr. Bruce, Walden, and Hoben
277 Lambton St.
Kincardine, Ontario
N2Z 2Y6
519-396-2641
519-396-3999 (f)
drwalden@tnt21.com

I authorize the release of the above-mentioned information.

Signature: _____

Dated : _____

Thank-you in advance for your help!