**Dr. Rosanna Porretta**
**24 Shore Street**
**Bolton, Ontario L7E 4T7**
**(905) 951-9511**
**(905) 951-8784 Fax**
**info@boltonfamilydentalcentre.com**

## Authorization For Release Of Dental Records

To: Dr. _____

Address: _____

City: _____

Phone Number: _____

Fax Number: _____

**I hereby authorize you to transfer my / our dental records and associated radiographs to the office of Dr. Rosanna Porretta, and or Dr. Xhillari.**

**Kindly provide the following information:**

**Date of initial examination:** _____
**Last recall examination:** _____
**Last scaling / polishing:** _____
**Last BW's, Panorex, FMS:** _____

Any other pertinent information they may require including pending treatment, etc.

Thank you for your co-operation in this matter.

Patient Name(s): _____

_____

Signature: _____

Date: _____