Arkona Dental Clinic
14 Union St.
Arkona, ON
N0M 1B0

REQUEST FOR RECORD RELEASE

519-828-3895
Fax: 519-828-3116
arkonadental@execulink.com

Dear Dr. _____

Thank you for the care you have shown for the following patient(s) in the past. In order to provide them with the same continuing care, please forward all dental radiographs along with the dates of their last 01202, 02142, 02601 that was billed out to the Arkona Dental Clinic at your earliest convenience.

Name: _____ D.O.B. _____

Name: _____ D.O.B. _____

Name: _____ D.O.B. _____

Name: _____ D.O.B. _____

Signature of Patient, Parent or Guardian & Date:_____