

# **Brock North Dental**

Dr. Daniel Zigler D.D.S

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Date: \_\_\_\_\_

Dear Doctor:

Regarding Patient(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby give permission for the originals or duplicates of **dental radiographs** and patient(s) **clinical records and notes** for the above patient(s) to be forwarded to this office.

To help us with our records please include the following dates:

**Patients names:** \_\_\_\_\_

**New Patient Exam:** \_\_\_\_\_

**Panorex:** \_\_\_\_\_

**Full Mouth Series:** \_\_\_\_\_

**Last Recall:** \_\_\_\_\_

**Thank You for your co-operation**

\_\_\_\_\_

Patient Signature