**To Whom It May Concern:**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby release all radiographs and dental records on file from the office of Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to Dr. Robert Axelrad and Associates. Please forward a copy of dental treatment records, radiographs and any other information which may be pertinent to their treatment.

* Date of last Bitewings \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Date of last Panorex or Full Mouth Series \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Please include the date of the last Complete Oral Exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Name (Printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please mail records and radiographs to:

Dr. Robert Axelrad and Associates

40 Finchgate Blvd.

Suite 121

Brampton, Ontario, L6T 3J1

Digital Records can be sent to:

[draxelrad@gmail.com](mailto:draxelrad@gmail.com)