shifa DENTISTRY

1-1940 Bank Street, Ottawa, ON K1V 7Z8
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Date:

To:
Telephone #:
Fax:

AUTHORIZATION FOR RELEASE OF RECORDS

I, ______________________________, hereby authorize the release of all radiographs and records to:

Dr. Rabia Syeda
1-1940 Bank Street
Ottawa, Ontario
K1V-7Z8
Fax #: 613.521.8670

Patient/Guardian Signature: __________________________________

Patient Name: ____

Telephone #: ____

Address: ____