



**OSHAWA CENTRE DENTAL OFFICE**

419 King St. West

Oshawa, Ontario

L1J 2K5

905-571-2443 fax 905-571-3172

I \_\_\_\_\_ authorize the release of my dental radiographs and dental records to the above named office.

Please include the following family members in my above request.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Code** \_\_\_\_\_ **Date**

01103 \_\_\_\_\_

02120 \_\_\_\_\_

02601 \_\_\_\_\_

11111-2-3 \_\_\_\_\_

11101 \_\_\_\_\_

You can email documents to **treatmentodental@rogers.com**.

Thank you in advance

Dr. Bernard Rubin

[www.oshawacd.com](http://www.oshawacd.com)