DR. REYMARIE YABUT DENTISTRY
PROFESSIONAL CORPORATION
215 Woolwich Street Guelph, Ontario N1H 3V4 (519)824-4770 www.dryabutsmile.com

Dear Dr. ________________, I hereby consent to, authorize and request the release of my/our dental records and any radiographs to Dr. Reymarie Suarez-Yabut.

Family members to be transferred (1)________________ (2)________________

(3)________________ (4)________________

Date of last Comprehensive Oral Exam (1)________________ (2)________________

(3)________________ (4)________________

Date of last FMX/PAN (1)________________ (2)________________

(3)________________ (4)________________

Date of last recall & BW's (1)________________ (2)________________

(3)________________ (4)________________

Thank you very much and hoping for your immediate response regarding this matter.

Signature of Patient/Parent/Guardian: ________________________

Print Name: ________________ **DOB:** ____________ Date: ____________