# Authorization For Release of Records

Patient Name: _____

Date of Birth: _____

Address: _____

Name of Previous Dentist _____

I hereby authorize you to transfer x-rays and / or study models to:

**Dr. Eric Smith**

**Barrie Orthodontics**
**9 Bradford Street**
**Barrie, Ontario**
**L4N 3A6**
**info@barriesmiles.ca**

Signature of patient/parent or legal guardian _____

Date Signed _____
yyyy / mm / dd