GRACE FAMILY DENTAL
DR. QUOC QUACH, DDS
WELCOME TO THE FAMILY!

Records Release

(Patient consent for dental records)

I,_____ herby authorize_____to release my dental radiographs and/or records to Grace Family Dental. I also authorize the release of any dental radiographs and /or records for my dependants or for the patients for whom I am guardian.

Patient Name:_____Date of Birth:_____

Patient Name:_____Date of Birth:_____

Patient Name:_____Date of Birth:_____

Patient Name:_____Date of Birth:_____

Patient Name:_____Date of Birth:_____

Please forward digital radiographs and date of complete exam to info@gracefamilydental.ca.

X _____ X _____

Signature Date

Dr. Quoc Quach
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e: info@gracefamilydental.ca
website : gracefamilydental.ca