



**Dr. Tracey Mulhall**

**Release of Information Consent Form**

I, \_\_\_\_\_, hereby authorize the release of my complete dental records, and/or those of my dependants for the continuation of my/their dental care and treatment. I allow my x-rays to be emailed between the two offices stated.

\_\_\_\_\_ & Dr. Tracey Mulhall \_\_\_\_\_.

Please forward current bitewing and periapical x-rays taken within the last year and panoramic x-ray taken within the last three years to the provider requested below.

**Address of New Provider:** \_\_\_\_\_  
\_\_\_\_\_ Dr. Tracey Mulhall \_\_\_\_\_  
\_\_\_\_\_ 200-605 5 Ave SW \_\_\_\_\_  
\_\_\_\_\_ Calgary, AB T2P-3H5 \_\_\_\_\_  
\_\_\_\_\_ 403-262-4914 \_\_\_\_\_  
\_\_\_\_\_ info@drtraceymulhall.com \_\_\_\_\_

Thank-you in advance for your prompt response to this request.

Sincerely

\_\_\_\_\_  
**Signature (Patient/Parent/Guardian)**

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