Dr. Tracey Mulhall

Release of Information Consent Form

I, _____, herby 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