**DR. MALAEKEH ZARRABIAN**
**Dentistry Professional Corporation**
**42 Ellesmere Road**
**Toronto, ON M1R 4C1**
**Tel: (416) 444 5566**
EMAIL: info@drmz.ca

**X-RAY RELEASE**

Dear _____
Dentist's name

This letter is to request that my dental records and x-rays to be released to Dr. Zarrabian at the address above.

Please provide the date that was done:

X-rays (PAN, bitewings, PA's): _____

Exam:_____

Scaling:_____

Name: _____
Patient's name

Signature:_____
Patient's signature (Parent/Guardian)

Date:_____

Thank you