Dental Records Release Form

Patient transferring records: _____ Date:_____

Date of Birth: _____

Phone number: _____

Other Family Members to transfer: _____

_____

Previous Practice Name & address _____

_____

In order to comply with privacy legislation enacted by both the Federal and Provincial Governments, we require that the following be read and signed by all patients or their guardians prior to releasing any personal information to third parties.

I permit the release of my personal information including medical & dental history, treatment records, periodontal probing depths, diagnostic tests results, radiographs & photographs to:

Dentistry on Bank
1596 Bank Street
Ottawa,On K1H7Z5

Fax:613-733-5583 Phone:613-733-7754
Email: Ottawa@dentistryonbank.com

This permission remains in force until it is revoked in writing by the authorized signature.

Signature: _____ Date:_____

Printed: _____