North Dumfries Dentistry Dental Record Release Form

To (Your Previous Dentist & Office Name): _____

Please find enclosed the dental record release form for the following patient,

Name: _____ & Date of Birth: _____

They hereby authorize the release of all requested patient records to: North Dumfries Dentistry located on 32 Northumberland Street Ayr Ontario via:

☐ Email ☐ In-Person

We are requesting that the following patient records be sent to us. As well, we ask that you please provide dates.

☐ Radiology Images ☐ Treatment Plans ☐ Last Recall Exam ☐ Last Full Exam

☐ All Billing Records

In addition, the patient is requesting the following be sent over:

Specific Records/Information on: _____

Specific Records/Information not to be released: _____

I hereby am granting North Dumfries Dentistry authorization to contact the listed denist office on my behalf for the release of my requested dental records. I understand that if redisclosed by the recipient it is no longer protected by the Authorized Service Provider named above. I am aware that this form only holds a one-year expiration date from the date of signature.

_____ _____

Signature of Patient or Patients Guardian Date

North Dumfries Dentistry

P: (519) – 394 – 2999

E: info@nddentistry.ca