Authorization to Release and Transfer of Dental & Medical Records

_____

Patient name (last, first)

_____

Date of Birth

_____

Street Address

_____

City, Province, Postal Code

_____

Telephone #

I HEREBY AUTHORIZE:

_____

Name of sending dentist

_____

Street Address

_____

City, Province, Postal Code

_____

Telephone #

TO RELEASE MY MEDICAL/DENTAL RECORDS TO: Aspen Springs Dental Centre

_____

Name of Receiving Dental Office

_____

Street Address

_____

City, Province, Postal Code

_____

Telephone #

I consent to the release of my personal health information from Aspen Springs Dental Centre including all X-RAYS, DENTAL AND MEDICAL RECORDS in accordance with the specifications listed above, and this is my authorization for doing so. I understand that details of my previous financial arrangement will be released to facilitate a smooth transfer of care.

Signature:

_____

Date:

_____

If signed by person(s) other than the noted patient above, state the relationship:

_____

and I am authorized to do so because the Patient is (a):

□ Minor □ Incapable □ Other: _____