RECORDS RELEASE REQUEST

Date: ___________________________

To: ____ (Doctor/Physician)

Address: ____

Phone Number: ____

Dear Doctor,
I hereby authorize you to release any information or records regarding my dental treatment to Tottenham Village Dentistry, at the below address. Please send any current x-rays or any information that would be helpful in my ongoing dental treatment.
Thank you for your cooperation.

____ _________________________
(Printed Patient Name) (Date of Birth)

____
(Patient Signature)

Names and dates of birth of other family members to transfer:
____

Please include:
- All current dated x-rays (if digital, please email)
- Date of last Complete Exam ______________________________
- Date of last cleaning ___________________________
- Any other pertinent information

Please send or email to: Tottenham Village Dentistry
80 Queen St. S, Tottenham ON, L0G 1W0
info@tottenhamvillagedentistry.com
(905) 406-2329