Dentistry on Kennedy©

General Dentistry · Cosmetic · Restorative · Orthodontic

Dr. Ellen R. Felaire & Associates
1414 Kennedy Rd · Unit 20
Scarborough · Ontario
M1P 2L6

Tel: 416·292·8767
Fax: 416·292·4072

info@mydentalplace.ca
www.mydentalplace.ca

Date: ___________________

To: Dr. ______________________________
Tel: ______________________________
Fax: ______________________________

AUTHORIZATION TO RELEASE AND TRANSFER OF DENTAL RECORDS

Patient's Name: ____________________________________
Date of Birth: ____________________________________

Including my family members? Yes [ ] No [ ]

Names: ____________________________________
____
____
____

Requested Information:

- ☐ Photocopy of treatment records
- ☐ Most recent FMS, Panorex, or Ceph, PA, BW
- ☐ Date of previous New Patient Exam (01103) _________________
- ☐ Date of previous Recall Exam (01202) _________________
- ☐ Date of previous Specific Exam (01204) _________________

The above patient(s) would like to thank you for the care you have shown them in the past and would ask that in order to insure continuity of care, the past x-ray and any other pertinent information be forwarded to this office as soon as possible. All information received will of course be held in the strictest confidentiality. Please send all documents preferably by email, or mail them to the above address.

Your prompt response to this request is greatly appreciated.

The Dental Team of Dr. Ellen Felaire

I hereby authorize the release of my dental records as requested above.

Patient`s Signature ___________________________ Date: _____________________