Village Dental • Record Release Authorization

I, _____ (name of patient, parent or guardian), hereby request and authorize _____ (name of previous dentist/dental clinic) to provide Village Dental with copies of my/my family's dental records, radiographs and any other information as outlined below.

Phone number of previous dentist/dental clinic ____ – ____ – ____

Email of previous dentist/dental clinic _____

Signature of patient, parent or guardian _____ Date DAY MO YEAR

TO BE COMPLETED BY PREVIOUS DENTIST/DENTAL CLINIC

In order for Village Dental to continue providing the above named patient(s) with the same level of care he/she is accustomed to, please provide the following information:

- A summary of all information pertinent to the above noted patient(s) continued treatment.
- Copies or original films from most recent full mouth series, panoramic films and films taken within the last 24 months.
- Date of last new patient exam (01103)

  DAY MO YEAR
- Date of last full mouth series and/or PAN (02102 or 02601)

  DAY MO YEAR
- Date of last BW (02142 or 02144)

  DAY MO YEAR
- Date of last recall appointment (01202)

  DAY MO YEAR

Your cooperation with this request is greatly appreciated. Thank you. If you have any questions, please contact us at info@villagedental.ca or (416) 233-9638.