Newcastle Smile Centre

Authorization for release of Dental Records.

Date: _____

Transfer Office: _____

Fax#/E-mail Address: _____

I, _____, consent to the release and transfer of
PRINT NAME HERE
records to Newcastle Smile Centre for the purposes of its computer scanning and digital duplication. This would include summaries of all information pertinent to my continuing treatment. (Clinical records and all current radiographs)

Please provide the following information to ensure the best optimal care: FOR OFFICE USE ONLY

Date of last new patient exam (01103) _____

Date of last recare examination (01202) _____

Dates if scaling appointments and the units used _____

_____

Date of last panorex (02601) _____

Date of last bitewings (02141 or 02144) _____

I have given consent for the disclosure of this information and I request that my records be released.

Family Members: _____
FAMILY MEMBER NAMES HERE

_____

Thank you for your timely response,

Signature: _____
SIGN HERE

Newcastle Smile Centre
361-1 King Ave East, Newcastle, Ontario
L1B 1H4
Phone (905) -446-5500 Fax (905)-446-5502
E-mail info@newcastlesmilecentre.com