EJC DENTISTRY

118 Stinson Street
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905-522-1188
info@forgreatteeth.com

Authorization of Release of Dental Records

To: _____

Office Phone: _____

1. Patient Name: _____ Date of Birth:_____
2. Patient Name: _____ Date of Birth:_____
3. Patient Name: _____ Date of Birth:_____
4. Patient Name: _____ Date of Birth:_____
5. Patient Name: _____ Date of Birth:_____

We at EJC Dentistry would like to thank you for the care you have shown the above patient(s) in the past. We ask that in order to insure continuity of care, past radiographs, treatment records, notes from referring specialties, and any other pertinent information be forwarded to this office.

Records Requested with Dates

Patient Name	New Patient Exam	Last Recall	PAN/FMX	Bitewings	Scaling	Insert of crowns/bridges

All information will be held in the strictest of confidence.

I hereby authorize the release of my records to EJC Dentistry as requested above.

Signature of Patient/Guardian: _____ Date: _____