Records Release Form
Innovation Drive Dental

Date:

To:

From:

Re: Request for Patient Records

To Whom It May Concern:

I (Mr./Mrs./Miss) _____ hereby request and authorize the release of my/ my family's dental records and radiographs to Dr. Jennifer Shulman and/or Dr. Corey Shulman of Innovation Drive Dental.

_____
Patient Signature

Please email x-rays to: info@innovationdrivedental.com

To the Dentist:

After RCDSO Guidelines:

Patients have the right of access to a copy of their complete dental records. Please honour the above request in a timely manner by forwarding:

Copies of original files of most recent full-mouth series, panoramic film taken within the last 24 months. Furthermore, kindly provide us with the following information in order to help us in serving this patient's dental needs.

Date of new patient examination:

Date of last recall examination:

Date of last bitewing radiograph:

Date of last panoramic/fms radiograph:

Your co-operation is greatly appreciated. Thank you.

Innovation Drive Dental
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f. 905-264-7033