Request for Release of Dental Records

I, _____(print full, legal name), the undersigned, hereby authorize the release of the following dental records of mine:

- Copies of any radiographs taken within the last two years.
- Copies of dental records outlining treatments provided to me during the past twelve months (as of the signed date of this release) and any treatment planned or pending (If applicable).
- Please include the date of last Complete (New Patient) Examination and Panoramic Radiograph.

I also authorize the release of these same dental records applicable to my dependent child/children:

Name(s) of dependant(s) (if applicable) _____

Please forward these dental records to:

Young Dentistry
324 Guelph St. Unit 8
Georgetown ON
L7G 4B5.
T- (905)-873-4800
F - (905) 873-4821
smile@youngdentistry.ca

Signed _____ Date _____