AUTHORIZATION TO RELEASE DENTAL INFORMATION

(The execution of this form does not authorize the release of information other than the terms specifically described below.)

PATIENT NAME: BIRTHDATE:
ADDRESS:
POSTAL CODE: CITY: PROVINCE:
PHONE NO.: EMAIL:

I request and authorize **LANDMARK DENTAL CENTRE** to release the information specified below to the organization, agency or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

RELEASE REQUESTED INFORMATION TO:

___ ME (patient)
___ DENTIST/DENTAL OFFICE:
ADDRESS:
POSTAL CODE: CITY: PROVINCE:
PHONE NO.: EMAIL:

INFORMATION REQUESTED:

___ Copy of complete dental chart ___ All treatment rendered
___ Copy of dental xrays ___ Others (eg. Models -describe ____________________

Digital Copy (no fee)

By selecting Digital Copy you take full responsibility that the private dental records are going to be sent over the Internet without security and the ability to verify that receiving party successfully obtained the files. Furthermore, there is an understanding that the file format may not be compatible. We issue all documents in PDF format and x-rays in JPEG format.

PURPOSE OR NEED FOR WHICH INFORMATION IS TO BE USED:

___ Transfer of Records
___ Second Opinion
___ Other, please explain ____

AUTHORIZATION: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge.

I understand that the dental chart and X-rays are part of the original dental records that belong to **LANDMARK DENTAL CENTRE.**

We require 72 hours from the time of signature to process your request. Please note that this form MUST be filled fully including your Signature and Date

Please email the completed form to admin@landmarkdental.ca

Patient's Signature: ______________________ Date of Request: ______________________