5 Fairview Mall Drive   Ste. 230   Toronto, ON   M2J 2Z1

DENTAL RECORDS RELEASE FORM

We, at Fairview Dental Group (Drs. Rakowski and Dr. Colomby), would like to thank you for the care you have shown ______________________ in the past and would ask that in order to insure continuity of care , that past **x-rays** and **treatment records** (and any other pertinent information) be forwarded to this office.

______ Radiographs

______ Panorex

______ Charting

______ Any notes from referring specialties

Please Provide the Following Information:

Date of Last Full Mouth/Panorex ______________________________

Date of last Complete Oral Examination _______________________

Date of last Recall Examination _______________________________

Date of last scale-polish _____________________________________

All Information received will be held in the strictest of confidence.

Fax: 416-493-7260   416-493-4225   info@fairviewdental.ca

I hereby authorize the release of my records to Fairview Dental Group as requested above.

_______________________________   __________________________ *D.O.B.*__________

Patient Signature   Date