NEWCASTLE SMILE
DENTAL CENTRE

Authorization for Release of Dental Records

Date: _____

Transfer Office: _____

Fax#/E-mail Address: _____

I, _____, consent to the release and transfer of
PRINT NAME HERE
records to Newcastle Smile Dental Centre for the purposes of its computer scanning and digital duplication. This would include summaries of all information pertinent to my continuing treatment (clinical records and all current radiographs).

Please provide the following information to ensure the best optimal care: **FOR OFFICE USE ONLY**

Date of last new patient exam (01103) _____

Date of last recall examination (01202) _____

Dates of scaling appointments and the units used _____

_____

Date of last panorex (02601) _____

Date of last bitewings (02142 or 02144) _____

I have given consent for the disclosure of this information and I request that my records be released.

Family Members: _____
FAMILY MEMBER NAMES HERE

_____

Thank you for your timely response,

Signature: _____
SIGN HERE

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