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North York, ON M3H 3R9
www.stonebrookdental.ca
Tel.: 416-636-4227
Fax: 416-636-4228
stonebrookdental@rogers.com

AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

TO: DR.____

PATIENT'S NAME:____

ADDITIONAL FAMILY MEMBERS__________________________________

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We, at Stonebrook Dental office, and the above patient, would like to thank you for the care you have shown them in the past and would ask that in order to insure continuity of care that the most recent radiographs and any pertinent information be forwarded to this office as soon as possible.

All information received will of course be held in the strictest of confidence.Would you please send all documents to our office.

I herby authorize the release of my records as requested above.

Patient's name:____

Signature:______________________________Date:______________________

Best Regards,

Dr. Nubia Diaz De Cornejo DDS