Request for Release of Information

Living Wellness Dental

Patient last name : _____ first name : _____ mid name : _____ Your birthday: ____/____/_____

Home address: _____ Apt. #: _____ City: _____ Province: _____ Postal Code: _____

☐ I hereby authorize Living Wellness Dental to obtain the information or records from _____

for the following patients:

_____

_____

_____

_____

Information being requested:

☐ Bitewings ☐ PA's ☐ Panorex ☐ Study Models

☐ Probing Charts ☐ Full Chart

☐ This is to certify that I consent to the dental procedures agreed to be necessary or advisable for myself, or my child / legal dependent, including the use of local anesthetic or other drugs as indicated. I understand that there are no guarantees that the procedures agreed to be necessary will resolve all or any of the described symptoms. I will assume responsibility for fees associated with those procedures, and I consent to the collection, use and disclosure of my personal information as set out above.

Patient Name: _____ Signature: _____ Date: _____

Email: reception@lwdental.ca