Authorization to Release Records and X-rays

*Each adult patient must sign his/her own Authorization form-**PLEASE PRINT***

Previous Dentist Name: _____ **Tel. #:** _____-_____-_____

Fax #: _____-_____-_____ **Email Address:** _____

I_____ authorize you to release any dental records (including all
(Patient Name)
radiographs) to Dr. Arash Ghassabei , Dr. Dacko and Dr. Hoffman at:

Artin Dental Office
Stock Exchange Tower
130 King Street West, PO Box 131
Toronto, Ontario
M5X 1A4
(416) 364-4150

or email information to **info@artindental.com**

Please provide dates of service for the following procedures:

COE (01103): _____ Recare (01202): _____

FMX (02102): _____ Polish (11101): _____

PAN (02601): _____ Fluoride (12101): _____

BW (02142): _____

COMMENTS: _____.

I release you from all liability that may arise from this authorization.

_____ _____
(Patient Signature) (Date)

_____ _____
(Witness) (Date)