+1613 854 8007

info@seniordental.ca

www.seniordental.ca

Authorization Form for Release of Dental Records

Patient Information:
Full Name: ______________ ______________ Date of Birth: ______________________________

Facility Name: ______________________________ Facility Address: ______________________________

Family/ POA (Power of Attorney) Information (if patient is not self-POA):
Full Name: ______________________________ Address: ______________________________

Phone Number: ______________ Cell: ______ ________Work: ______ ________

I, ______________________________, hereby authorize the release of the patient's dental records from:

Previous Dentist Office:
Dentist Name: ______________________________ Address: ______________________________

Phone Number: ______________ __

The purpose of this authorization is to allow the transfer of the patient's dental records to:

New Dentist Office:
Name: Dr. Farideh Ali-Mohammadi (DDS)
Address: 368 Sweetflag St. Nepean Ontario K2J 5Y7
Phone Number: +1 613 854 8007
Email: info@seniordental.ca

This authorization specifically permits the release of the following dental records:
- X-ray Documents
- Treatment history
- Diagnostic records (including models, photographs, and charts)
- Any other pertinent information related to the patient's dental care

I understand that the information released under this authorization may be protected by Dentistry Act, 1991 including but not limited to the (HIPAA), (PHIPA) and (PIPEDA).
This authorization shall remain valid unless revoked in writing by family/ POA. I understand that I have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance on it.

Family/ POA's Signature: ______________________________ Date: ______________