Downtown Georgetown Dental

Dr. Lida Hosseini

40 Main St S

Georgetown ON L7G 3G4

905-877-4371

frontdesk@dg.dental

AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

To: Dr.

Address:

City:

Phone Number:

Fax Number:

I hereby authorize you to transfer my/our dental records and associated records to the office of **Dr. Lida Hosseini**, **Downtown Georgetown Dental**.

Kindly, provide the following information:

Date of complete initial exam: _____

Last recall examination: _____

Last scaling/polishing: _____

Last BWs, Panorex, FMS: _____

Any other pertinent information they may require including pending treatment, etc.

Thank you very much.

Patient Name(s):

_____

Signature Date