50 Westmount Road N, Unit 225, Waterloo, ON, N2L 2R5

Phone: 519-578-2720 Fax: 519-578-2720

E-mail: dentalwestmount@gmail.com

Patient's Name: _____ DOB: _____

(Please print)

Dear Doctor,

I hereby authorize you to release any information or records regarding my dental treatment to Westmount Dental at the above address. Please send any current x-rays or any information that would be helpful in my dental treatment.

Thank you for your cooperation.

Previous Dentist Name: _____

Previous Dentist Location: _____

Patient Signature: _____ Date: _____