Authorization for Release of Dental Records

Patient Name: _____ Date of Birth: _____

I hereby authorize _____ to release and transfer a copy of my complete dental records to:

Moonlight Dentistry
Address: 401- 600 Sherbourne St
Toronto, ON. Postal Code: M4X 1W4
Phone: 6474793010
Email: info@moonlightdentistry.ca

The records to be released include, but are not limited to:

- Dental charts and treatment history
- Digital X-rays and radiographs
- Clinical notes
- Periodontal records
- Photographs (if available)
- Any other relevant dental records

I understand that this authorization is voluntary and may be revoked in writing at any time, except to the extent that action has already been taken based on this authorization.

Patient Signature: _____
Printed Name: _____
Date: _____