



## REQUEST FOR PATIENT RECORDS

DATE:

TO:

FROM:

To Whom It May Concern:

I (Mr./Mrs./Miss.) \_\_\_\_\_ hereby request and authorize the release of my/my family's dental records and radiographs to Simcoe Family Dentistry.

\_\_\_\_\_  
Patient Signature

By typing your name you agree that all the information above is current and true.

To The Dentist:

After RCDSO Guidelines:

Patients have the right of access to a copy of their complete dental records. Please honor the above request in a timely manner by forwarding:

-A summary of all information with the above patient's continued treatment (chart photocopy is acceptable)

Date of last complete examination: \_\_\_\_\_

Date of last recall examination: \_\_\_\_\_

Date of last bitewing and panoramic radiographs: \_\_\_\_\_

-Copies of original films of most recent full mouth series, panoramic film and film taken within the last 24 months. This is so we can provide our patient's with the same level of care they have been accustomed to.

Your co-operation is greatly appreciated.

Thank-you