Records Release Request

Date:______________________________

Doctor:____________________________

- All recent Radiographs
- Date of last New Patient Exam:_______________
- Date of last Recall:__________________________
- Date of last Specific/Emergency Exam:_________
- Date of last Pan:____________________________
- Date of last Full mouth series:_______________

I authorize the release of dental records relevant to treatment, or copies of such, and hereby request that they are transferred to:

Kay Dental Care

50 Doctor Kay Drive, Unit C19

Schomberg, ON L0G 1T0

✆: (905) 590-9055

Fax: (905) 590-9050

Email: info@kaydentalcare.ca

Patient Name:_____________________________________

D.O.B: ______________________________

Patient, Parent, or Guardian Signature:_____________________________