Information Release Form

Date:_____

to: Dr. :_____

Phone:_____ Fax:_____

I hereby authorize you to release the most recent dental radiographs and dental records to:

L'ESPLANADE DENTAL CENTRE

DR.KATIA DOUMIT

181 Bank St., M1 Ottawa, ON. K2P 1W5

Tel: (613)232-8000 Fax: (613)232-8100

or email to: request@lesplanadedental.com

for: (name of patient(s))

_____

I release you from all legal responsibility that may arise from this authorization.

Signed:_____Witness:_____

THANK YOU