Release of Records Request

Attention: _____ Date: _____

Phone: _____

Fax: _____

Please forward all dental records to aid in the continued care of the following patient(s):

Name	Date of Birth	Date of last 01103/01202

Please forward these records by email, fax or mail at your earliest convenience to:

☐ wavedental port perry

H6 – 1535 Hwy 7A
Port Perry, ON L9L 1B5

Phone: 905-982-0399
Fax: 905-982-0311
Email: portperry@wavedental.ca

☐ wavedental uxbridge

8-307 Toronto St. S
Uxbridge, ON L9P 0B4

Phone: 905-862-2228
Fax: 905-862-2211
Email: info@wavedental.ca

I _____, request and authorize the release of my (family's) dental records to Wave Dental.

_____ _____

Patient/Guardian Signature Date