FAIRMOUNT DENTAL

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# Dental Records Release

I, (name)_____, hereby authorize the release of copies of my x-rays and records by (previous dentist)_____

I understand that the custodian of my original dental records is the dentist and that the information contained in the records belongs to me. I agree to accept copies of such records and to pay any fee(s) for duplication and processing, as required.

By signing this I allow to have the records released to Fairmount Dental. If documents are to be sent by e-mail, I understand that this is not a private mode of communication and my dental records may be intercepted by someone other than the intended recipient.

Please release the following records:

- ☑ Panoramic radiograph taken within the last 5 years
- ☑ Periapical and bitewing radiographs taken within the last 2 years
- ❑ Other _____

Patient Name (print) _____ Date of Birth _____

Patient Signature _____ Date _____

**NOTE TO PROVIDER:**

Please label all records with proper dates. Digital records can be sent via SecureSend in attention of Dr. Marius Caragea or by email at **info@fairmountdental.ca**

Please mail physical copies to **Fairmount Dental, 205-9825 Fairmount Drive SE, Calgary, AB, T2J0R9.** Do not hesitate to contact us if you have any questions or concerns.