PACIFIC SPIRIT
DENTAL CENTRE

Date: ____________________

RELEASE OF RECORDS AUTHORIZATION

DR.____

____

____FAX#________________________

I hereby request and authorize the transfer of my dental records to the indicated office.

Please include the following (if available):

All radiographs (full mouth surveys, if available)
Copies of periodontal charting; particularly pockets, furcas and recessions
Letters and/or reports from specialist(s)
Study models or duplicates

Please send all available records to:

- ☐ Dr. Ernst J. Schmidt, Inc.
- ☐ Dr. Troy A. Martin
- ☐ Dr. Anne Yen

Pacific Spirit Dental Centre
#215 – 2150 Western Parkway, UEL
Vancouver, BC, Canada, V6T 1V6

Thank you very much,

Patient (full name):____

Patient signature: ____

Patient DOB: _______________________Phone:__________________________