DENTAL RECORDS RELEASE FORM

Patient Name to Transfer: _____

Date of Birth: _____ Phone Number: _____

Other Family Members to Transfer:

1. _____ 2. _____

3. _____ 4. _____

Previous Dentist or Dental Practice Name: _____

Address: _____

City: _____

Phone Number: _____

Please forward the following information that you have: x-rays, probing depth chart, charting and photographs to **Dr. John L. Chiasson**.

I hereby give you permission to release any and all dental records to
Dr. John L. Chiasson

_____ _____

Patient's Signature (guardian if minor) Date

If records are digital, please e-mail to: **contact@drjohnchiasson.com**

Or mail to:

Dr. John L. Chiasson Dentistry
1470 Mosley Street, Unit #8
Wasaga Beach, ON L9Z2C2