auroradentalcentre
89 Wellington St. East Aurora, ON L4G 1H7
phone: 905.727.9220

Aurora Dental Centre
Records Release Form

Date:

To:

From:

Re: Request for Patient Records

To Whom It May Concern:

I (Mr./Mrs./Miss) _____ hereby request and authorize the release of my/ my family's dental records and radiographs to Dr. Michael Kohen of the Aurora Dental Centre.

_____
Patient Signature

To the Dentist:

After RCDSO Guidelines:

Patients have the right of access to a copy of their complete dental records. Please honour the above request in a timely manner by forwarding:

- A summary of all information with the above patient's continued treatment (chart photocopy is acceptable)
- Copies of original films of most recent full mouth series, panoramic film and film taken within the last 24 months. This is so we can provide out patients with the same level of care they have been accustomed to.

Your co-operation is greatly appreciated. Thank you.

Dr. Michael Kohen
Aurora Dental Centre
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Aurora, ON L4G 1M1
(905) 727-9220
(905) 727-9212 fax