ESSENCE DENTAL

6-233 Earl Stewart Drive, Aurora, Ontario L4G 1Y3 | 905-503-8686 | info@essencedental.ca

Please complete the following requested info and fax back to 905-503-8680 or e-mail to info@essencedental.ca

To: Dr _____

Phone #:_____

Fax #: _____

Essence Dental is requesting the release of dental records for the patient(s):

		Date of most recent:			
Patient(s) Name:	**Complete Exam**	**Recall**	**BW**	**PAN**	**FMX**
_____	_____	_____	____	____	____
_____	_____	_____	____	____	____
_____	_____	_____	____	____	____
_____	_____	_____	____	____	____
_____	_____	_____	____	____	____

Please forward radiographs and the above information to our office at your earliest convenience.

I, _____, authorize the release of my dental records to be sent to Essence Dental.

Patient/Guardian Signature _____ Date:_____

Thank You,

The Essence Dental Team