

**PARK DRIVE DENTAL CENTRE INC.
DR. BOB BOADWAY AND DENTAL ASSOCIATES
12 PARK DRIVE SOUTH, STOUFFVILLE, ONTARIO L4A 1G4**

INFORMATION RELEASE FORM:

PHONE: 905- 640-6688

EMAIL: parkdrivedental@yahoo.com

FAX: 905 -640-8950

TO DR. _____ FAX# _____

IN THE TOWN OF _____

I _____ (NAME OF PATIENT)

AUTHORIZE YOU TO FURNISH DENTAL RECORDS ACCORDING TO THE RCDS GUIDELINES:

Patients have the right of access to a copy of their complete dental records.

Please honor the above request in a timely manner by forwarding:

- 1) A summary or photocopy of all information with the above named patient's chart.
- 2) Copies of original films of most recent full mouth series of panoramic film and film taken within the last 24 months.

TO THE PARK DRIVE DENTAL CENTRE INC:

- DR. BOB BOADWAY
- DR.BETH WILLISTON

I RELEASE YOU FROM ALL LEGAL RESPONSIBILITY OR LIABILITY THAT MAY ARISE FROM THIS AUTHORIZATION:

_____ DATED: _____

PATIENT'S SIGNATURE

MODERN DENTISTRY STEEPED IN SMALL TOWN TRADITION!