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

TO DR.__________________________________EMAIL ADDRESS___________________________

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: c/o.

DR. BOB BOADWAY

DR. BETH WILLISTON

DR. CHRISTOPHER CHEKAY

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!