smilesUnlimited
DENTAL CENTRE

AUTHORIZATION FOR RELEASE OF PERSONAL RECORDS

Date: ____

DR. ____

____

____

(Enter Name & Address of Doctor who currently has your records.)

E-mail/FAX NUMBER: ____

I hereby request and authorize transfer of my dental records to the office indicated below. Please include the following (if available):

- All radiographs (full mouth surveys and/or panoramic, if available)
- Copies of periodontal charting (if available)
- Letters /reports with other health professionals (if available)
- Study models or duplicates (if available)

Please send all available records to:

- ☐ Dr. Bernard Jin
- ☐ Dr. Carlee Buek
- ☐ Dr. Sangwoo Ham
- ☐ Dr. Stefanie Leonor

Smiles Unlimited Dental Centre
949 Como Lake Avenue
Coquitlam, BC
Canada V3J 3N2

Thank you!!

Patient (Full Name): ____

Patient Signature: ____

Patient DOB: ______________________________ Telephone: ____________________

Dr. Bernard Jin & Associates
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