AUTHORIZATION FOR RELEASE OF PERSONAL RECORDS

To: **Smiles Unlimited Dental Centre** Date: _____
949 Como Lake Avenue
Coquitlam, BC V3J 3N2
FAX NUMBER: 1-866-390-8014
Email: reception@smilesunlimited.ca

I, _____, hereby authorize transfer of my dental records
(PRINT YOUR FULL NAME)
from Smiles Unlimited Dental Centre to:

(Enter Recipient's information here):

Name of Dental Practice: _____

Address of Dental Practice: _____

Email of Dental Practice: _____

Phone number of Dental Practice: _____

PLEASE READ CAREFULLY BEFORE MAKING YOUR SELECTION:

☐ **BASIC RECORDS TRANSFER***:
The standard practice for records transfer between offices usually involves **X-ray images only**. We will perform this at no-cost **one (1) time only**. Thereafter, there will be a charge of $25 for all subsequent basic record transfers.

☐ **COMPREHENSIVE RECORDS TRANSFER***:
There is a charge for a comprehensive records transfer. If you are authorizing a comprehensive records transfer, kindly note the rates for scanning/copying/courier delivery of items outlined below:

- Treatment History / Treatment Plan / Periodontal Chart ($1/page)
- Letters/reports involving other healthcare professionals ($1/page)
- Study models or duplicates ($20/model)

☐ **REMOVAL FROM THE ACTIVE PATIENT LIST**:
I wish to have my name removed from the Active Patient List; as such, I acknowledge that I will no longer receive reminder phone calls/correspondence from Smiles Unlimited Dental Centre.

Your Full Name: _____

Signature: _____ E-mail: _____

Birthdate: _____ Telephone: _____

Please note that record transfers may take up to 2 weeks.