Authorization to Release Records and X-rays
Each adult patient must sign his/her own Authorization form PLEASE PRINT

Previous Dentist Name: ____________________________ Tel. #: ______-____-_______

Fax #: ______-____-_______ Email Address: ________________________________

I, ____________________________, authorize you to release any dental records (including all radiographs) to Dr. Arash Ghassabei, Dr. Dacko and Dr. Hoffman at:

Artin Dental Office
Stock Exchange Tower
130 King Street West, PO Box 131
Toronto, Ontario
M5X 1A4
(416) 364-4150

or email information to info@artindental.com

Please provide dates of service for the following procedures:

COE (01103): ________________ Recare (01202): ________________

FMX (02102): ________________ Polish (11101): ________________

PAN (02601): ________________ Fluoride (12101): ________________

BW (02142): ________________

COMMENTS: ________________________________________________________

I release you from all liability that may arise from this authorization.

__________________________________________
(Patient Signature) ____________________________
(Date)

__________________________________________
(Witness) ____________________________
(Date)