Sari Novack D.D.S.
Family and Cosmetic Dentist

Dental Record Release

Date: ____________________

To: Dr. ____

Address: ____

City: ____________________ Province: ____________________ Postal Code: ____________________

Phone: ______________________________________ Fax: ______________________________________

I authorize Dr. ____________________ to release a photocopy of my dental treatment records and originals or duplicates of any current radiographs to the office of:

Dr. Sari Novack
4211 Yonge Street, Suite 201
Toronto, ON
M2P 2A9
416-224-2114
416-224-1282 (fax)
reception@sarinovackdentistry.com

Patient's Name:____

Date of Birth: ____

Signature: ____

(Parent or legal guardian must sign if patient is a minor)

OFFICE USE ONLY

Date request sent: ____

Date records received: ____