

Date: \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF PERSONAL RECORDS**

DR. \_\_\_\_\_

\_\_\_\_\_ 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
- Letters and/or reports from other health providers & specialist(s)
- Study models or duplicates

Please send all available records to:

- Dr. Bernard Jin
- Dr. Kevin Lauwers

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

Thank you kindly.

Patient (full name): \_\_\_\_\_

Patient signature: \_\_\_\_\_

Patient DOB: \_\_\_\_\_ Phone: \_\_\_\_\_