AUTHORIZATION FOR RELEASE OF INFORMATION

CLIENT'S NAME _____

DATE OF BIRTH (Day/Month/Year) _____

Previous Dentist Name _____

Email _____

Phone # _____ Fax #_____

ADDRESS OF WHERE RECORDS ARE TO BE SENT:

R and A Dentistry – Dr. Ania Mamiasheva and Dr. Rustam Mamiashev
Suite 805 – 2303 4 St. SW
Calgary, AB T2S 2S7
EMAIL: randadentistry@gmail.com

Information being
requested:_____

I do hereby authorize the release of my dental records to R and A Dentistry.

SIGNATURE_____

DATE:_____