DR. ED HOBEN
FAMILY AND COSMETIC DENTISTRY

35 Wellington St. N.
Woodstock, ON N4S 6P4
Ph: 519-539-4868 Fax: 519-539-1674

Release of Records Authorization

Dear Dr. _____Phone#_____

Address: _____Email:_____

Re: _____Date of Birth _____

Name of additional family members:_____

_____

Thank you for the care you have shown in the past to the above patient(s). In order to provide them with the same continuing care, please provide the following information: *Dental office to fill out dates below.

Dates of most recent:

Complete/New Patient Exam: _____

Recall Exam:_____

Prophy and Scale:_____

Bitewing x-rays:_____

Panorex:_____

PA's:_____

Please send all digital x-rays to referrals@hobendentistry.ca.
If unable to provide digital x-rays please mail hard copies to above address.

I hereby authorize the release of x-rays and pertinent details of my treatment, and that of my family.

_____ _____
Patient/Guardian Name (Print or Type) **Date**

_____ _____
Patient/ Guardian Signature (Sign or docusign) **Date**