PLACE D'ORLEANS DENTAL OFFICE

Information Release Form

PRESENT DENTIST: _____
FAX NUMBER: _____
PATIENT'S NAME: _____

Please forward copies of my dental records/radiographs to:

Place D'Orleans Dental Office
110 Place D'Orleans Drive Box 317
Orleans, Ontario
K1C 2L9
(613) 830-4827

ATTENTION: **Dr. Maranger**
Reasons for transfer:

1. Referral to Specialist _____
2. Second Opinion _____
3. Insurance Predetermination _____
4. Other: _____

I release you from all legal responsibility or liability that may arise from this authorization and confirm that my account with your office is at zero balance.

PATIENT'S SIGNATURE: _____

WITNESS SIGNATURE: _____

DATE: _____