DR. SHANE SNIDER
DENTISTRY
5959 Anderson St -Brooklin, ON - LIM 2E9
905.655.6255

Record Release Form

Email: info@drshanesnider.com
Fax: 905 655 6244

Date: _____

To Doctor/Office: _____

I authorize the release of all dental records, or copies of such, and request that they are transferred to Drs. Snider and Margolian Dentistry for myself and/or my family members.

Patient(s) Name(s): _____

_____

_____

_____

Kindly provide dates of the last

Complete Oral Exam

Recall

Bite wing x-rays

Full mouth series

Panoramic

Scaling

Patient Signature: _____ Date: _____

Thank you for your cooperation!