To:

Date:

Fax # _____

From: **STRATHCONA DENTAL WORKS**

112-555 Strathcona Blvd SW
Calgary, Alberta
T3H 2Z9
Tel # (403) 242-2000 Fax # (403) 686-0990
Email: reception @ strathconadental.com

RE: PATIENT INFORMATION TRANSFER

PATIENT NAME _____

DATE OF BIRTH (Y-M-D) __ __ __ __ / __ __ / __ __

AUTHORIZED RELEASE

I/We,

_____

Authorize the release of dental; related information including (but not limited to) x-rays to Strathcona Dental Works.

_____

Patient/Guardian

Please initial the appropriate box:

☐ I consent to having my records transmitted by HIPAA compliant mail or fax.

☐ I consent to having my records transmitted by non-HIPAA compliant email. (By initialing this I understand that email is not a private mode of communication and that my dental records may be intercepted by someone other than the intended recipient.)

(HIPAA = Health Insurance Portability and Accountability Act)