



**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. Beaupré**  
**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: \_\_\_\_\_