

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,

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

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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)