Richmond Hill Sleep Dentistry
250 Harding Blvd. W., Unit 406
Richmond Hill, L4C 9M7
Tel: 1-800-917-788 or 905-237-8412 Fax: 1-800-581-3635
Email: info@RHSleepDentistry.ca

Consent for Release of Personal Health Record

I, _____, authorize_____
(Print your name) *(Print name of health information custodian)*

to disclose

☐**the personal health information consisting of** _____***(print name of referred patient)***

Date and Record of most recent & relevant dental treatment related to specialist referral _____

Date and a Duplicate of most recent & relevant dental radiographs _____

Insurance Company and Policy Number _____

to

◉ **Richmond Hill Sleep Dentistry**
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Richmond Hill, Ontario
L4C 9M7
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○ _____
_____
_____
_____
_____

I understand the purpose for disclosing this personal health information to the person noted above. I understand that I can refuse to sign this consent form.

My Name:_____ **Address:**_____

Home Tel.:_____ Work Tel.: _____

Signature:_____**Date:**_____
