Thrive
DENTAL CARE

I hereby authorize _____ (former dentist)

to provide **Thrive Dental Care** with copies of my dental records with respect to any dental care and treatment that I have received.

I understand that the specific type of information to be disclosed includes a detailed report of examinations, treatment provided, x-rays and all other records which pertain to me.

This consent is effective until such date that I cancel the consent. I understand that the information obtained as a result of this consent may be used after the cancellation date.

Patient name (print) _____ D.O.B. _____

Signed (patient): _____

Signed (parent/ guardian): _____

Date: _____

Address to which records should be sent:

Thrive Dental Care

9608 Cameron St. Burnaby BC

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