Dental Records Release Form

SL Dental Centre
1000 Mission Professional Centre
2303- 4th Street SW
Calgary, Alberta T2S 2S7
Phone: (403) 228-5367 Fax: (403)229-2876

Email: info@sldentalcentre.ca

Date: _____

Patient Name to Transfer: _____Date of Birth: _____

Other family members records
requested_____

Previous Dental Practice Name: _____

Phone Number_____

Please forward my dental records to SL Dental Centre on 4th St.

Thank you.

Signature_____