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Request for Transfer of Patient Records

CHART NOTES

from previous 5 years incl. relevant specialist reports

RADIOGRAPHS

PAs /BWS taken within last 2 years; any PAN taken within last 5 years

Patient requesting transfer: _____

Date of Birth (dd/mm/yy) _____

I hereby authorize:

_____ (Dentist/Dental office name)

_____ (Office address)

_____ (Office phone number)

to release a copy of my charts to Wolfville Dentistry. In so doing, I release all legal responsibility for the care and keeping of my records in accordance with PIPEDA. I understand that my original chart will be kept on file with your office for future reference as per your office policy.

Other family member's charts to be released:

Thank you for your care. Please cancel any future appointments that I may have at your office.

Signature: _____ Date: _____