RELEASE OF RECORDS REQUEST FORM

To: Dr. Aram Mohajeri

46 John St	**104-451 King St West**	**1051 Queen St West**
Toronto, ON		
Canada		
M5V 3W1	**M5V 1K4**	**M6J 1H3**

I _____,

hereby request and authorize the release of my and/or my family members' dental records, including all recent radiographs, to:

Dr. _____

_____

_____

_____

Family members to include: _____

_____

_____

_____

_____

_____ _____

Patient, Parent or Guardian's Signature **Date**

JOHN ST
46 John St.
T: 416 977-1414
E: staff@ari.dental

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451 King St. W
T: 416 645-3344
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