DR. VICTOR SUN 4 Russell Street East, LINDSAY, Ontario K9V 1Z6 Phone: 705 324-0050

Fax: 705-324-0529

info@drvictorsun.com

Dear Dr._____, I hereby authorize and request the release of my/our dental records and any radiographs to Dr. Victor Sun.

FAMILY MEMBERS TO BE TRANSFERRED 1_____2_____

3_____4_____

DATE OF LAST COMPREHENSIVE ORAL EXAM 1_____2_____

3_____4_____

DATE OF LAST FMS, PAN 1_____2_____

3_____4_____

BWS DATE OF LAST RECALL & **1**_____**2**_____

3_____4_____

Thank you for your immediate response regarding this matter.

Signature of Patient, Parent or Guardian_____

PRINT NAME:_____**DOB**_____**DATE**_____