



Release of Records

Date: _____

I, _____ give authorization to the office of,
_____ to release my record to BluSky Holland
Cross.

Previous Dental Office Email: _____

Previous Office's Phone Number: _____

BluSky Holland Cross
1620-20 Scott Street
Ottawa, ON
K1Y4S7
Phone: 613-728-1511

Email: hollandcrossreception@blusky.dental

Patient Name: _____

Patient Signature: _____