CLINIQUE DENTAIRE ROY

# CONSENT FOR REFERRAL TO A DENTAL SPECIALIST

I, the undersigned, _____, understand that, for clinical reasons, my general dentist at the Dental Clinic Roy may recommend that I consult w ith a dental specialist (e. g., endodontist, periodontist, oral and maxillofacial surgeon, orthodontist, etc.).

I understand that this transfer of information respects confidentiality and that I may ask any questions before the documents are transmitted.

I acknowledge that this authorization is voluntary and that I may withdraw it at any time upon written request.

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Date : ____ / ____ / _____ Patient's signature : _____

Parent or guardian's signature, if patient is a minor.

Name of parent/guardian : _____

Date : ____ / ____ / _____ Parent or guardian's signature : _____
_

450-229-9573

Télécopieur 450-229-5373

1396, boul de Sainte-Adèle
Sainte-Adèle QC J8B 2N5

www.DentisteSainteAdele.com