In the Matter of the
Personal Information Protection and
Electronic Documents Act

Patient Authorization for Release of Information

I, _____, authorize Dr. I. Keith Corbett to release information pertaining to dental or orthodontic treatment and dental benefits or coverage

- to my dental plan and/or
- to referring or consulting medical or dental practices.

I understand that I may revoke this authorization, in writing, at any time.

_____ _____
Signature of Patient, Parent or Guardian Date

_____
Print Patient, Parent or Guardian Name