Release Form for Dental X-Rays

I, _____ DOB: _____ do hereby give permission to
(Patient Name) (Date of Birth)

have my current x-rays transferred to West 17th Avenue Dental Care.

_____ _____ _____
Print name **Signature of Patient or Parent / Guardian** **Date**

Please send to:

West 17th Avenue Dental Care
Scarboro Village
Suite 102, 1608 17 Avenue SW
Calgary, Alberta
T2T 0E3

Phone: (403) 244 – 1124
Email: info@west17avedental.ca