RELEASE FORM FOR DENTAL X-RAYS

I, _____DOB:_____ do hereby give permission to have

(Patient Name) (Date of Birth)

my current x-rays transferred to W17 Ave Dental Care.

_____ _____

(Signature of patient or parent/guardian) (Date)

Please send to:
W17 Ave Dental Care
#102, 1608-17th Ave SW
Calgary, AB, T2T 0E3

ph: (403)244-1124 fax: (403) 244-7654
info@west17avedental.ca