WEST 85TH DENTAL

#2110 8561 8 A AVE. SW, CALGARY AB, T3H 0V5

TELEPHONE: 403 246 5545

FAX: 587 349 1982

EMAIL: info@west85thdental.com

XRAY RELEASE CONSENT FORM

Patient Family's Name: _____

First Name Last Name

I, _____, hereby authorize you to release my x-rays to:

Be emailed to West 85th Dental

For all family members:

_____

_____

_____

Information Requested:

ALL CURRENT **2018 -2020** BITEWINGS, PA'S PAN DATED **2015** OR LATER

NAME OF PREVIOUS DENTAL OFFICE: _____

PHONE:_____FAX:_____EMAIL:_____

SIGNATURE:_____ DATE:_____

As per above Patient Verbal Consent