**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 Health Plus Dental Centre.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Please send to:

Health Plus Dental Centre

#205, 290 Midpark Way SE

Calgary, AB, T2X 1P1

(403)254-1300 fax: (403) 201-3511

healthplusdental@shaw.ca