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 Health Plus Dental Centre.

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

Please send to:

Health Plus Dental Centre
#205, 290 Midpark Way SE
Calgary, Alberta
T2X 1P1

Phone: (403)254-1300
Fax: (403) 201-3511
Email: info@healthplusdental.ca