Living Wellness Dental **(587) 600-6935**

X-Ray Release Form

THE FOLLOWING INFORMATION IS REQUIRED TO ENABLE US TO PROVIDE YOU WITH THE BEST POSSIBLE DENTAL CARE. ALL INFORMATION IS STRICTLY PRIVATE, AND IS PROTECTED BY DOCTOR-PATIENT CONFIDENTIALITY. YOUR DENTIST WILL REVIEW THE QUESTIONS AND EXPLAIN ANY THAT YOU DO NOT UNDERSTAND. PLEASE FILL IN THE ENTIRE FORM.

Contact Information

Client Full Name: _____ Date of Birth: _____

Street Address: _____ City: _____

Province: _____ Postal Code: _____

□ I hereby authorize Living Wellness Dental to obtain the information or records from the below practice.

Record Holder Practice Name: _____

Records for the Following Clients:

_____ _____

_____ _____

_____ _____

_____ _____

Information Being Requested:

□ Bitewings □ Panorex □ Probing Charts □ PA's □ Study Models □ Full Chart

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□ This is to certify that I consent to the dental procedures agreed to be necessary or advisable for myself, or my child/legal dependent, including the use of local anesthetic or other drugs as indicated. I understand that there are no guarantees that the procedures agreed to be necessary will resolve all or any of the described symptoms. I will assume responsibility for fees associated with those procedures, and I consent to the collection, use and disclosure of my personal information as set out above.

Signature

_____ _____ _____

Print Name Signature Date