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Dental X-Ray Release Form

Patient Information (CONFIDENTIAL)

Patient Name | Date of Birth

Additional Family Members to Transfer:

Last COE: | Last Recall: | Last BW: | Last Pan: | Last FMX:

Previous Dentist/Dental Practice Information

Dentist/Dental Practice Name:

Address: | Phone: | Fax:

Authorization

I hereby give permission and request to release any and all of my dental/treatment x-rays:

First & Last Name | Email Address

Signature

X

If X-rays are digital please send via email to: info@alpha-dental.ca