X-RAYS & RECORDS RELEASE FORM

Patient's Name: _____ **Birthdate:** _____

Parent's/Guardian's Name: _____ **Phone No.:** _____

o **To Metro Dental Care**
Unit 210, 40 Country Hills Landing NW
Calgary, AB, T3K 5P4
Phone: 403-262-2627
Email: metrodentalcarecalgary@gmail.com

o **From Metro Dental Care**

Dental Office Name: _____

Address: _____

City: _____ **Provice:** _____ **Postal Code:** _____

Phone: _____ **Email:** _____

I, _____, herby authorize and request the release of x-rays and records to be transferred between the two offices stated above.

Patient's/Parent's Signature: _____ **Date:** _____

X-rays released by: _____ **Initial:** _____ **Date:** _____