TUDOR GLEN
SMILE CLINIC
ST. ALBERT

XRAY RELEASE FORM

Reset Print

Name: _____

Address: _____

City: _____ Postal Code: _____

Phone Number: _____

I hereby authorize the release of any current dental x-rays.

FROM (dental clinic name and address):

_____

_____

TO: Dr. B Croutze
Tudor Glen Smile Clinic
2010 Tudor Glen Place
St. Albert, AB, T8N 3V4
reception@tudorglen.ca

Signature/Guardian Signature: _____

Date: _____ M M M M D, Y Y Y Y

Reset Print