



Beddington Dental Clinic

www.beddingtondentalclinic.com

Consent for Release of X-rays

I hereby authorize the release of dental related information and /or radiographs for the following patients:

Name

Date of Birth

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I understand that without my consent and signature on this document there will be no exchange of information nor will radiographs be forwarded to the requesting party.

Forward Digital X-rays to: admin@beddingtondentalclinic.com

Patient/Parent/Guardian Name (Print)

Signature

206-8120 Beddington Blvd. N.W.
Calgary, AB T3K 2A8
Tel: (403)275-4000

