NOSE
CREEK
DENTAL
CENTRE

Authorized Release of Dental Radiographs and/or Dental Related information

I hereby authorize the release of dental related information and / or radiographs for the following patient(s)_____.

I understand that without my consent and signature on this document; there will be no exchange of privileged information nor will radiographs be forwarded to the requesting party. All correspondence will be sent directly to the requesting provider. No exceptions.

Please forward to: Dr._____

Mailing Address: _____

_____

_____

Phone Number: _____

Email Address: **admin@nosecreekdental.ca**

_____ _____

Patient / Parent / Guardian Name Signature
Please Print

_____

Date

#1, 409 – 1 Avenue
Airdrie, AB T4B 3E2
(403)948-6684