west market dental
FAMILY & COSMETIC DENTISTRY

339-1851 Sirocco Drive SW
Calgary, Alberta T3H 4R5

phone: 403-246-8555
fax: 403-246-8557

email: info@westmarketdental.com

(For Patients Leaving West Market Dental)

PATIENT CONSENT FORM FOR THE DUPLICATION AND RELEASE OF XRAYS AND CHART

(One Form Per Adult)

Date _____

Permission is hereby granted to release information for the dental / medical history of _____.
(Patient's Printed Full Name)

Patient's Signature:_____
(or Legal Guardian if patient is under 18)

Printed Name Of Guardian (if applicable):_____

Relationship Of Guardian To Patient (if applicable):_____

Name And Address Of Dentist Where Records Are To Be Released
_____
_____
_____
_____

Specific Materials Requested:_____

Printed Name Of Witness:_____
(Witness must be over the age of 18)

Signature Of Witness:_____