



HIGHLAND DENTAL CLINIC

X-RAY RELEASE CONSENT

DATE: _____

I, _____, AUTHORIZE TO RELEASE ALL RELEVANT
DENTAL X-RAYS AND/OR RECORDS TO HIGHLAND DENTAL CLINIC.

Please send the requested records to our office as soon as possible.

PATIENT/ PARENT/ GUARDIAN NAME(S): _____

Day

Month

Year

PATIENT DATE OF BIRTH: _____

PATIENT / PARENT / GUARDIAN SIGNATURE: _____

Email: info@highlanddentalclinic.com

Phone: (403) 946-4265

Fax: (403) 946-4283