RELEASE OF DENTAL RADIOGRAPHS AND/OR DENTAL RECORDS

I, _____, hereby authorize the release of any dental radiographs (Panorex taken within the last 5 years; bitewings and periapical x-rays taken within the last year) and/or other records and have them transferred to:

Copperstone Dental
#119, 10 Copperstone St. SE
Calgary, AB T2Z 0V4

E-mail: treatment@copperstonedental.ca (for digital x-rays)
Phone: 403.263.0711
Fax: 403.263.0799

Please contact Copperstone Dental should you have any questions or concerns regarding the transfer of the aforementioned information.

Patient Name: _____
IF DIFFERENT THAN ABOVE (LIST CHILDREN'S NAMES)

Signature: _____
PATIENT / PARENT / GUARDIAN

Date: _____