X-Ray Release Form

Date: ______________________________

Dr. ________________________________
{Dentist you are requesting x-rays from}

I hereby authorize you to release all dental radiographs for__________________________
{first name}

__________________________. Please forward x-rays to:
{last name}

Cataraqui Dental Centre
Cataraqui Town Centre
945 Gardiners Road
Kingston, Ontario
K7M 7H4
613-384-4224
613-384-4337 fax

Signature: __________________________________
{patient signature}