Pure North Dental Clinic

Dental patient X-rays release form

Date: ____________________

Dentist requesting X-rays: Dr. Andriy Yegorovykh

Phone #: 587.293.0722

E-mail: info@purenorthdental.ca

Patient Name: ____

DOB: ____

Phone #: ____

I, ______________________________, **give my permission** to transfer copies of any x-rays to the above named dentist for the purpose of allowing to diagnose and plan treatment of my oral conditions.

Patient's signature ____

1. Fill out this form
2. Sign
3. Forward the form to a custodian/dentist that has your X-rays