EST. 2018

DENTAL WELLNESS CENTRE OF ST. ALBERT

X-RAY RELEASE FORM

P: 780.569.0082 **F:** 780.569.0086 **E:** info@DentalWellnessStAlbert.ca

225, 4 Versailles Avenue
St. Albert, Alberta T8N 7V1

DentalWellnessStAlbert.ca

E-mail Address: **gemma@DentalWellnessStAlbert.ca**

Dear Dental Provider:

Please release X-Rays, with dates, to the above office.
If sending Digitally please email to above email address.

Thank you in advance for your co-operation.

Date of last C.O.E

Patient/Family Name

Patient/Parent Signature
(Signature of Parent or Guardian if patient is a minor)