4th Avenue Dental Centre

DATE: _____

FROM: 4th Avenue Dental Centre
Dr. Kevin Schade
Dr. Kimberley Dharap
Suite 150, 140 – 4 Ave SW
Calgary, AB T2P 3N3
403-262-4988
info@4thavenuedental.com

TO: _____
_____
_____

I, _____, authorize my dental xrays and or records to be
(Patient Name Printed)
released.
PAN:
BW:
PA:

Thank you.

_____
(Patient signature)