4th Avenue
DENTAL CENTRE

DATE: _____

TO: _____

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

I, _____, authorize my dental xrays and or records to be
(Patient Name)
released to Dr. Schade's office.

Thank you.

_____
(Patient signature)