X-Ray Release Form

To Dr. _____________________________,

Please release x-rays for the following patient:

____

to our dental office. Our address is:

600 Alden Road, Suite # 205

Markham, Ontario

L3R 0E7

If you have any further questions, please do not hesitate to call us at 905-940-5229.

Thank you,

Markham Gate Dental Centre.

Patient Signature:_________________________________

Date: ____