tuscany dental centre

Authorization for Release of Dental X-Rays

I, _____ authorize **Tuscany Dental Centre** to release and forward my X-rays and/or patient information to:

Name of Dental Office: _____
Address: _____
Phone Number: _____

My reason for the request is:
☐Moving to another area
☐Seeking a second opinion
☐Other

Signature of Patient: _____
Date of Request: _____
Signature of Team Member Processing the Request: _____

Authorization for the Release of Dental X-Rays

I, _____ am requesting that you release and forward my X-rays and/or patient information to Tuscany Dental Centre:

Please send to:
Tuscany Dental Centre
2078, 11300Tuscany Blvd NW
Calgary AB T3L 2V7
Phone: 403-239-0010
Email: tuscandent@telus.net

Signature of Patient: _____

Date of Request: _____