


**Didsbury**   
**Smiles Dental**  
**(403) 335-9696**

#4-2409 16th St Didsbury, AB T0M 0W0

**X-RAY RELEASE**

**Date:**

**To:**

**Patient Name:**

**I hereby authorize you to release to:**

North Didsbury Smiles Dental  
Box 279  
#4, 2409 16<sup>th</sup> Street  
Didsbury, AB T0M 0W0

Information Desired:

**All current BW's / PA's (less than a year old) and PAN (less than 5 years old)**

**\*If digital x-rays, please email to [didsburysmilesdental@gmail.com](mailto:didsburysmilesdental@gmail.com)**

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Signature

Date