CROSSINGS DENTAL

#10 – 6 Aquitania Blvd W
Lethbridge, AB T1J5L4
P: 403.394.010
F:403.394.1622

Date: _____

To Whom It May Concern:

I _____authorize the release of all dental records
(Parent or Guardian)

and x-rays for:

_____

_____

_____

_____

And ask that they be transferred to:

Crossings Dental
#10 – 6 Aquitania Blvd W
Lethbridge, AB T1J5L4

E-mail: smile@crossingsdental.ca

_____
Signature (patient/guardian)