

Authorization for Release of Records

Westbrook Dental Centre

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Calgary, AB T3C 1S2
T-403-249-5536
F-403-246-5648

Dr. Scot Campbell*
Dr. Todd Cook*
Dr. Ralph Dubiensi*
Dr. Archie Tang

I hereby authorize or employees of
to release the following information regarding my dental records to Westbrook Dental Centre.

Radiographs:

SIGNATURE OF PATIENT (parent/guardian)

DATE SIGNED

WITNESS

***Upon receipt of this release form please forward the requested information in a timely manner to the above address. If you require the originals please notify us and we will duplicate the films and return the originals to you.

Westbrook Dental Centre contact: