Westbrook Dental Centre

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T-403-249-5536 F-403-246-5648

Dr. Scot Campbell*

Dr. Todd Cook*

Dr. Ralph Dubienski*

Dr. Siran Qin

Authorization for Release of Records

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)

____
Witness

____
Date Signed

Westbrook Dental Centre contact: ______________________