Scident Family Dental Clinic

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Vancouver, BC V7L 2P9
Canada
Phone: 604-985-7032
Fax: 604-985-7015

CONSENT TO RELEASE PATIENT X-RAYS

Date:
Forward to:
Doctor
Address:

For valuable consideration, I hereby irrevocably consent to and authorize the use by you, or anyone authorized by you, the loan or copy of any and all x-rays that you have taken of me for any purpose whatsoever, to Dr. ___________ without further compensation to me. All original films shall constitute your property, solely and completely.

I am over 19 years of age: Yes   No

Patient Name:
Patient Address:

Patient Signature:

Parent/Guardian (if applicable)

I hereby certify that I am the parent or guardian of , the model for whom named above, and for value received I do give my consent without reservations to the foregoing on behalf of him or her or them.

Date:

Print Name:
(Parent / Guardian)

Signature: