

DR. SYLVIA KOWALEWSKI  
Foothills Prof Building  
#260, 1620-29 St. N.W.  
Calgary, AB  
T2N 4L7  
Ph: 403-220-9660  
Fax: 403-220-9660

RELEASE OF XRAY CONSENT FORM

I \_\_\_\_\_ give permission to Dr. \_\_\_\_\_

To release my dental xrays to Dr. \_\_\_\_\_

On this day \_\_\_\_\_.

Signature of Patient \_\_\_\_\_