Algonquin College Dental Clinic
J109-1385 Woodroffe Ave.
Ottawa, Ont.
K2G 1V8

ALGONQUIN COLLEGE
Dental Programs

X-RAY RELEASE CONSENT FORM

Date:_____ Attn:_____

Telephone:_____ Fax:_____

Re: Patient Name: _____

Address: _____

Date of Birth: _____

I give authorization for Dr. _____ to send copies of my dental x-rays to:

Algonquin College Dental Clinic
Room J109
1385 Woodroffe Avenue
Nepean, Ontario K2G 1V8
613-727-4723 ext: 2017
Fax: 613-727-7616

dentalclinic@algonquincollege.com

Please include the most current x-rays, in addition to any full mouth series, and panoramic radiograph taken within the last five years.

_____ _____

Print Name Signature