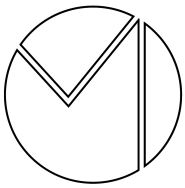

Consent to Release Dental Records

Date:_____

I, _____, hereby authorize _____ to release my Dental Records to Maxwell Dental.

Patient/Guardians Signature:_____

D.O.B:_____

Notes:

_____

_____

_____

Please kindly call, fax or email us with any additional information or questions.

Maxwell Dental
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Calgary, Alberta T3A 2N1
Tel: 403-286-2622, Fax: 403-286-3554 Email: records@maxwelldental.ca