# NOSEHILL
## DENTAL CENTRE

**#101, 1829 Ranchlands Blvd NW**
**Calgary, AB T3G 2A7**

## Patient Record Request

I, ________________________consent to have________________________
(*Print Name*) (*Name of Dentist or Practice*)
release my current Radiographs to Nosehill Dental Centre.

Please forward Radiographs to:

**Nosehill Dental Centre**
**#101, 1829 Ranchlands Blvd NW**
**Calgary AB T3G 2A7**
**403 241 1900**

If digital images are available, please email to:
**admin@nosehilldental.com**

________________________________ ____________________
*(Signature of Patient)* *(Date)*