Langdon Crossing Dental
#4, 720 Centre Street NE
Langdon, Alberta, T0J1X1
403-954-2099
e-mail:langdoncrossingdental@gmail.com (Please send information to email)

Consent for Disclosure of Personal Information

I, _____, consent to the release and transfer of radiographic images and photographic pictures to Langdon Crossing Dental for the purpose of evaluation, diagnosing, and documentation of my treatment.

I acknowledge that I have been made aware of the reasons for the disclosure of the above information, and the risks and benefits associated with consenting or not consenting to its release.
I understand that I may revoke my consent at any time, by providing a signed, written statement to Langdon Crossing Dental.

Signature: _____ Print Name: _____

Date: _____

Hello,

I'd like to ask you to send x-ray pictures of our patient . Consent form is attached in encrypted file.

Thank you,

Regards,
Langdon Crossing Dental.