



Record Transfer / Access Consent Form

I _____ (full name)

Date of Birth _____

Of _____

_____ (street address)

(if applicable) and those of my following dependants

request that my clinical records or copies thereof (including radiographs and photographs where applicable) be sent to

Rockingham Dental Centre
PO Box 187
Rockingham 6168

Or email:
reception@rockinghamdental.net

I understand that the original records remain the property of the dentist who created them

Signature _____

Date _____

Please request records from (Name of Dental Practice)

Save form to computer
before pressing Email Form