TRANSFER OF MEDICAL RECORDS CONSENT FORM

I, _____ Patient Name

of, _____ Patient Address

_____

_____ Date of Birth

Hereby Authorise, _____ Name of previous Dentist

_____ Name of previous Practice

Please release electronic or hard copy of my **Patient records** including **summary and X-Rays** to:

- By mail: Central Dentists Brighton, 10/353 Beaconsfield Trace, Brighton QLD 4017 or
- By email: info@centraldentistsbrighton.com.au

Name of Dentist: _____

Practice Name & _____

Postal Address: _____

_____

Signature: _____

Date: _____

OFFICE USE ONLY

Copy Sent: _____/_____/_____ Signature of Practice Representative: _____

Note Entered in Practice Software

Notes:

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