Portway Dental Practice

Patient Authorisation to Transfer or Forward Dental Records

I, [ ], hereby request and authorise [ ] to turn over my dental records to [ ] on [ ] or to forward a copy to my new dentist, whom I have indicated below. I understand that, in the absence of an alternative designation, my records will be transferred to [ ].

By authorising this transfer, I understand that I am not impairing Dentist [ ] right of access to my records, when necessary, during the time period in which I was under his/her care.

Details of new dentist, specialist, consultant, patient, attorney, insurer, etc.

Surname [ ] Forename [ ]

Contact number [ ]

Address [ ] Post Code [ ]

Forename

Surname

Signed