THE GAP DENTAL PRACTICE

I, ..., hereby authorise

Dr ..... of (Dental Practice) .....

To release my dental records or copies thereof *(including radiographs and photographs where applicable)*

(If applicable) and those of my following dependants

.....

.....

.....

And to provide such records to

Dr .....

of The Gap Dental 5/23 Glenaffric St The Gap

I understand that the release of these confidential records is at the discretion of the treating dentist and that the original records remain the property of the dentist who created them.

Signature Date

.....

Full Name.....

Address.....

Telephone.....