

Permission for Release of Dental Records

Patient Details:

Name.....

Address.....

D.O.B.....

**I.....hereby give permission for the release
of my dental records and any radiographs
from.....**

**to be forwarded to Glen Forrest Dental, 4 Hardey Rd, Glen Forrest.
6071**

Signed.....

Date.....

Confidentiality

**This facsimile is intended to be transmitted to the recipient named. If you are not the
intended recipient, any use, disclosure or copying of this document (s) is unauthorized. If
you receive this document in error, please contact (08) 92988187.**