Rockingham Dental Centre
57 Thorpe Street, Rockingham WA 6168
PO Box 187, Rockingham 6168

Rockingham Dental Centre
excellent care • gentle touch

Record Transfer / Access Consent Form

I _____ (full name)

Date of Birth _____

Of _____

_____

_____ (street address)

hereby authorise the release of my Dental records or copies thereof (including radiographs and photographs where applicable) (if applicable) and those of my following dependants

_____

_____

_____

for the purpose of

☐ Transfer Request: to transfer to another Dental Practice or Dental Specialist.
Please complete the following information of the Dental Specialist you wish to transfer your records to.

Name: _____

Address: _____

_____

Phone: _____

☐ Access Request: to view copy of records whilst on premises.

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.

Please Note: Current privacy legislation requires proof of identity to be ascertained before giving a person access to their records. Giving false or misleading information is an offence.

Signature _____

Date _____

Identification cited by _____

Type of identification cited _____

Save form to computer before pressing Email Form

Email Form

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admin@rockinghamdental.net www.rockinghamdental.net