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)

(if applicable) and those of my following dependants

_____

_____

_____

request that my clinical records or copies thereof (including radiographs and photographs where applicable) be sent to

Rockingham Dental Centre
PO Box 187
Rockingham 6168

Or email:

reception@rockinghamdental.net

I understand that the original records remain the property of the dentist who created them

Signature _____

Date _____

Please request records from (Name of Dental Practice)

_____