DENTAL RECORDS RELEASE REQUEST (New Patient)

DATE: ____________

To: ___________________________________

____

____

Email: ____

I, ____ (DOB: ______ /______ /__________)

of ____

authorise for copies of my dental records to be released to:

No Gaps Dental

Please submit them via their website - https://support.nogapsdental.com/hc/en-us/requests/new (select Dental Records)

Please include all

- Clinical notes (all on file, or up to past 7 years)
- Consent documents
- Radiographs, tracings, measurements
- Photographs
- Any other records that you deem significant / important

Patient's Signature: _____________________________________ Date: ___________

(For patients **under 18yrs of age**, a parent / guardian must complete the details below, and sign the records request)

Parent / Guardian's Name:			
Parent / Guardian's Address:			
Parent / Guardian's Signature:		Date:	

Thank you for your co-operation!