DENTAL RECORDS RELEASE REQUEST
(Existing Patient)

DATE: ____________

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

of ____

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

Name / Company / Dentist:	
Contact Phone No.:	
Email:	

I understand that I will not be permitted to remove the contents of my dental records from the premises of the dental practice, nor will I be permitted to alter or erase any information contained in the dental record.

I understand the dental records released will consist of clinical notes, radiographs, and intra-oral photographs, unless otherwise requested.

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:	

Please submit this form via the Request page on our website.
https://support.nogapsdental.com/hc/en-us/requests/new **(select Dental Records)**