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| To: |  |
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| Phone: |  | Fax: |  |
| Email: |  |  |  |

**REQUEST TO FORWARD DENTAL RECORDS**

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| I: |  |
| DOB: |  |
| Address: |  |
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Hereby express written consent for a copy of my dental records to be forwarded to:

**Dr.Prasad Karlapur**

**Harrison Dental Care
97/11, Wimmera Street
Harrison ACT 2914**

To obtain copies of all relevant dental records including:

* All treatment notes
* All correspondence to and from specialists
* Radiographs
* Medical history forms

\*digital radiographs or photographs can be emailed to reception@harrisondentalcare.com.au

Kindest Regards

|  |  |
| --- | --- |
| Patient (or guardian) Signature: |  |
| Printed Name: |  |
| Relationship to patient: |  |
| Date: |  |