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Dr Oliver Connell provider no. 4902041B

Tracy Burt, Dental Therapist

**DENTAL RECORDS REQUEST FORM**

I request the release of the personal dental records of:

FULL NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FULL NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FULL NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FULL NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FULL NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

from\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please forward e-mail xrays and all other relevant information to the e-mail address provided below by \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

[**godental@dentegrity.com.au**](mailto:godental@dentegrity.com.au)

Signature of person requesting records\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dr Pasricha, Dr Connell, Tracy Burt – Dental Therapist

Signature of Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_