165 Myrtle Street
Myrtleford VIC 3737
PO Box 257 Myrtleford
p. 03 5752 2221
smile@greatalpine.dental
www.greatalpine.dental

Request to Release Dental Records

Practice Name .....

Dentist's Name .....

Address .....

Town/Suburb ..... Post Code .....

Email .....

I hereby authorize the release of my dental records or copies of such and request that they be transferred to:

Dr Dr Amit Kapoor.....
requesting Dentist's name
Great Alpine Dental
PO Box 257
Myrtleford, VICTORIA 3737
e: smile@greatalpine.dental
p: 03 5752 2221

Patient's Name Person TEST..... Date of Birth 1/01/1998.....

Patient's Signature ..... Date 18/02/2021.....

PLEASE SEND COPIES OF RECORDS & X-RAYS
BY EMAIL (IF POSSIBLE). THANK YOU!