Patient Record Transfer Request Form

For a patient requesting information/dental records be transferred to another dentist.

Patient Details

Full name	
Date of birth	
Address	
Telephone number	
Email address	
Practice name	

Details of the personal information being requested

Information to transfer	
If you only want to transfer information relating to a certain period, specify the dates here	From To
Means of transfer (post or secure email)	

Person or organisation to transfer to

Name	
Address	
Telephone number	
Relationship to patient	

I am the patient named above and I give consent for Bupa Dental Care to transfer my information to the organisation named above. I understand that Bupa Dental Care will accept this consent for one transfer only.

Signed	
Print name	
Relationship to patient (if patient 15 or under)	
Date	