

Dr George Malliaros  
Dr Tracey Quach  
Dr Arun Aynikkal  
Ms Ursula Sweeney

Dr Enrique Velasquez  
Dr Shelton Jeyaratnam  
Dr Silvia Paredes  
Ms Nasrin Zaferanian

### **Transfer of Dental Records Patient Consent Form**

I hereby give my permission for Banyule Dental to **release and/or obtain** copies of my dental records and x-rays **to/from** the following practitioner:

Name of Dentist / Practice: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

I understand that I am responsible for any fees incurred during the copying or transfer of records, in accordance with the Privacy Regulations.

#### **Patient Information**

Patient's Full Name: \_\_\_\_\_

Date of Birth (DOB): \_\_\_\_\_

Patient Address: \_\_\_\_\_

Patient/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_