

10 Thurloe Street, South Kensington, London, SW7 2ST Tel: 020 7584 5551 Email: enquiries@londonsmiles.com

## **Records Release Request**

Date:	
Name of Patient:	
Address:	
Telephone:  Date of Birth:	
Telephone:	
I request/authorise the transferred to:	ne release of my dental records and or radiographs and request they be
Myself at:	Email Address:
Or Dental Practice:	
Marco Gilmour	
Signature of Patient	