Patient Consent for Release of Information

The practice has a legal and ethical obligation to protect patient confidentiality. The practice will keep any information given in the strictest of confidence following the guidelines and regulations set out by the General Dental Council, Patient Confidentiality, and the Data Protection Act.

Patients Name …….....

Address …….....

D.O.B …….....

I, Hereby confirm my consent for release of information to the below named persons.

Person 1 …….....

Relationship to patient …….....

Person 2 …….....

Relationship to patient …….....

I confirm that I understand the Patient Confidentiality Policy and that the practice will only disclose the minimum information for the purpose.

Signed by patient:

Date: