TANDARTSENPRAKTIJK
DE NIEUWEGRACHT

Authorization form to transfer a patient file

I, the undersigned

Patient name: ----------

Date of Birth: ----------

Address: ----------

Postal Code & City of residence: ----------

O Has had his/her patient file handed over personally

O Authorizes to transfer his/her patient file to he following (dental) office:

(Dental) office name: ----------

Address: ----------

Postal Code & City of residence: ----------

Signature patient: ----------

Date: ----------