Patient Consent Form

I (Full name)

of (Address)
( )
( )
( )

understand that .... (insert name of dentist) is undertaking the Postgraduate Diploma in in Primary Dental Care

I consent to records of my dental treatment, including photographs, radiographs and models of my teeth and jaws, being used for the purpose of supporting an entry for the assessment. No part of the records, including the case report of my treatment, may be reproduced or divulged to anyone outside the assessment process without my further consent.

I understand that I am entitled in accordance with current legislation to scrutinise these records, including my case presentation transcribed from the records, and may ask for copies (for which I may be charged reasonable expenses).

My consent is only in respect of the dental practitioner whose name appears above.

I have been given a copy of this consent form.

Signature Date

Patient (parent/guardian in the case of a child under the age of 16)