This is to advise that you grant permission for me to retain, in locked files, details of your address, age, medical details and details of treatment for a period of eight years.

The information is necessary to enable me to formulate adequate treatment for you and will not be passed on to any third party.

At the end of the eight -year period the record will be destroyed.

I understand and grant permission for the above actions.

Name (Printed):

Signature

Date