Department of social Protection- Treatment Benefit consent form

Name……..PPSN……D.O.B……

I the undersigned authorise Mullane Dental to use my personal data for the purpose of checking my eligibility for Treatment Benefits and to allow for the processing of the payment claim in respect of treatment's that I have received

I understand that I may revoke this consent at any time by contacting the Department

Signature of patient_____

Signature on behalf of dental practice_____

Date