Patient Authority to Release Dental Records

SECTION A

I (patient), ..., DOB: .....,

hereby authorise my previous treating dentist

....., of

(address)..... to release

my dental records or copies thereof (*including radiographs and photographs where applicable*)

and those of my following dependants (*if applicable*)

.....

.....

.....

And to provide such records by email, fax, mail, courier or personal delivery to

Aberdeen Dental Centre

1/60 Aberdeen Street, Albany WA 6330

Signed: .....

Name: (in full).....

Address: .....

.....

.....

Telephone: .....

Dated: .....

SECTION B (for office use only)

Form sent: ..... (Date, Type and Signature)

Records Received : ..... (Date and Signature)

Unit 1/60 Aberdeen Street, Albany WA 6330
Ph: (08) 9842 2345 Fax: (08) 9842 2384
Email: reception@aberdeendental.com.au Website: www.aberdeendental.com.au
ABN 45 601 858 771