Patient Authority to Release Dental Records

Ochre Medical Centre
9 Ochre Way
Sippy Downs, QLD 4556

Ph: (07) 54564 066
Fax: (07) 54501 466
Email: info@allsmilesfamilydentistry.com.au

I, ___________________________________, hereby authorize my previous treating dentist:

Dr……………………………….of (address)……………………………………………………………………………………………………
………

To release my dental records or copies there of (including radiographs and photographs where applicable)
And those of my following dependents (if applicable)
………………………………………………….
………………………………………………….
………………………………………………….
………………………………………………….

And to provide such records to:

All Smiles Family Dentistry
By email: info@allsmilesfamilydentistry.com.au
Fax: 07 54501 466

Name (in full)………………………………………………..
Address ………………………………………………………..
………………………………………………………..
………………………………………………………..
Phone: ………………………………………………………..

Signed: ………………………………………………………..
Date: ………………………………………………………..