Patient Authority to Release Dental Records

I, _____, hereby authorize Dr _____,

of _____ Dental practice,

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

(if applicable) and those of my following dependents:

_____

And to provide such records to:

Dr Mark Calvert
New Farm Dental Studio
P.O. Box 1490
New Farm QLD 4005
Ph: 07 3254 3222

info@newfarmdentalstudio.com.au

I understand that the release of these confidential records is at the discretion of the treating dentist and that the original records remain the property of the dentist who created them.

Signed: _____ Date: _____

Name: *(in full)* _____

DOB _____

Address: _____

_____

Check Form