DENTAL
CENTRE MAROOCHYDORE

Patient Authority to Release Dental Records

I,……DOB ……

Address ……

……

……

Telephone ……

Hereby authorise my previous dentist Dr ……..

Of ……
To release my dental records or copies thereof
(Including X-Rays and photographs where applicable)
I understand that the release of these confidential records is at the discretion of my previous treating dentist Dr ……..and that the original records remain the property of the dentist who created them.

And those of my following dependants:

…….. DOB ……

…….. DOB ……

…….. DOB ……

And provide such records to my current dentist **- Dr …** ……..

of Dental Centre Maroochydore 23 Beach Rd, Maroochydore 4558

Date ……

Signed ……

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