THE GAP DENTAL PRACTICE

Patient Authority to Release Dental Records

I, ……., hereby authorise my previous treating dentist

Dr……., of (practice) ……

to release my dental records or copies thereof, including radiographs and photographs where applicable.

(if applicable) and those of my following dependants.

……..

……..

……..

Please provide such records to

Dr……., of The Gap Dental Practice.

(info@gapdental.com.au)

I understand that the release of these confidential records is at the discretion of the treating dentist

Dr……. and that the original records remain the property of

the dentist who created them.

Signed

……

Name (in full): ……..

DOB: ……..

Address: ……..

……..

Telephone: ……

Dated: ……