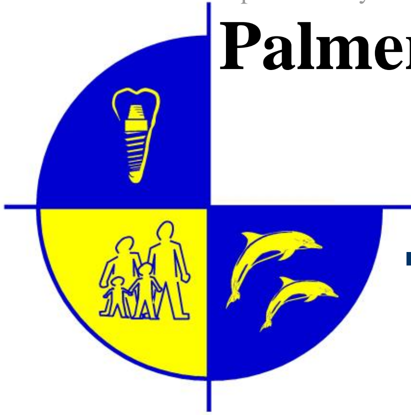
Dental Corporation Pty Ltd. T/as



Palmerston Dental Surgery

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Email: pds@palmerstondentalsurgery.com
(ABN 92124730874)

PATIENT AUTHORITY TO RELEASE DENTAL RECORDS

I,………………………………………………………………., hereby authorize my

previous treating Dr…………………………………………………….…………of

(Practice name) ……………………………………………………………………………

…………………………………………………………………………………………..

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

(If applicable) and those of my following dependants

Name:.………………………………………………DOB:…………………………….

Name:…………………….………………………DOB:…………………………….

Name:…………………….………………………DOB:…………………………….

Name: (in full) ……………………………………….……

Date of Birth: …………………………………………….

Address: ……………………………………………..........

…………………………………………………..

…………………………………………………..

Phone: ……………………………………………………

Signed: __________________________________ Dated: ______ / _____ / ___________

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.