simply dental
noosaville

Dr Diane Dawes B.D.S.(Hons)

42 Mary Street,
Noosaville 4566
Sunshine Coast

Patient Authority to Release Dental Records

I, ……. hereby authorise

Dr (current) ……

of (address) ……
……
telephone ……

to release my dental records or copies thereof *(including radiographs and photographs where applicable)* and those of my following dependants *(if applicable)*

……
……
……

and to provide such records to

Dr (diane) ……

of Simply Dental, 42 Mary Street, Noosaville QLD 4566

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

Dr (diane) ……

and that the original records remain the property of the dentist who created them.

Signed ……

Name: (in full) ……
Address: ……
……
……
Telephone: ……
Dated: ……

1) copy for treating dentist *2) copy for dentist requesting records* *3) copy for patient*

Phone: 07 5474 3131 fax: 07 5474 3132 email: simplydental@bigpond.com.au