simply dental
noosaville

dr.diane dawes B.D.S.(Hons)
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noosaville 4566

Patient Authority to Release Dental Records

I, ……. hereby authorise for my dental records or copies thereof (including x-rays and photographs where applicable to be released from:

Previous Dentist ……

Address ……

……

Telephone ……

Fax Number ……

and those of my following dependants/children *(if applicable)*

……
……
……

and to provide such records to

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

Signed ……

Name: (in full) ……
Address: ……
……
……
D.O.B. ……
Telephone: ……
Dated: ……

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