Patient Authority to Release Dental Records

Section A:

*1……………………………………(patient) hereby authorise my previous treating dentist Dr ………………………………………………………
of (address)…………………………………………………………………
……………………………………………………………………………………
To release my dental records or copies thereof (including radiographs). (if applicable) and those of my following dependants.*

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and to provide such records by registered mail or personal delivery to:

*Dr ……………………………………………………………………….(requesting dentist)
of (address) ………………………………………………………………………………*

Signed: ………………………………………………

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

Section B:

*Records were registered mailed on…………… (date) reference no:……………
or hand delivered by ……………………………………(name) on date…………..*

Signed ………………………………….. Name………………………………….

Section C:

Records Received: ………………………….. ………. (name of requesting

agent and signature) ……………………………………………….