Shop 32-33A / 230 Napper Road

Arundel QLD 4214

Ph: 07 5563 3133

Email: info@bedental.com.au

Patient Authority to Release Dental Records

I/We _____, hereby authorise

Name of Dentist/Specialist Practice Name, _____

To release our dental records or copies thereof (including radiographs)

And those of my following dependants (if applicable)

_____

_____

_____

And to provide such record to (please circle):

Dr Stuart Craig / Dr David Heitkonig / Dr Kristy Savvas / Dr Kajal Raniga

Be Dental

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

Dr _____

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

Signed: _____ Phone: _____

Full Name: _____ Date: _____

Date of birth: _____