PATIENT AUTHORITY TO RELEASE DENTAL RECORDS

I ……hereby authorise

Dr ……

of (address) ……

……

Phone:…….. Fax:……

to release my dental records (or copies thereof) including radiographs and photographs where applicable, and to provide such records to:

Dr Charlotte de Courcey-Bayley BDS (Hons) Sydney University
Holistic Dental Care
PO Box 233
St Leonards
NSW 1590

FAX: (02) 9436 1289
PHONE: (02) 9439 2090
EMAIL: info@holisticdentist.com.au

I understand the release of these confidential records is at the discretion of the Doctor and that the original records remain the property of the dentist who created them.

Signed

……

Your Name (in full): ……

Your Address: ……

……

……

Phone: ……

Date: ……