Redcliffe Dental
EST 1958

Ph: 07 3284 2244
Fax: 07 3283 5244
E-mail: info@redcliffedental.com.au
Website: www.redcliffedental.com.au

Patient Authority to Release Dental Records to Redcliffe Dental

I, _____(Full Name)

Date of Birth: _____

Of (Home address): _____

_____

Authorise (Previous Dentist/Practice Name):_____

_____

Of (Previous Dentist Address): _____

_____

Phone (Previous Dentist): _____

Email (Previous Dentist): _____

To release my dental records and radiographs via email or registered post to:

Redcliffe Dental
31 Anzac Avenue, Redclife 4020 QLD
info@redcliffedental.com.au

I understand that the release of my dental records is at the discretion of the treating dentist and I acknowledge that the original records remain the property of the treating dentist who created them.

Signature: _____
Print Name: _____
Date: _____