PATIENT AUTHORITY TO RELEASE DENTAL RECORDS

I …....., of

Address.....

.....Post code ….....

DOB.....Contact telephone.....

Hereby authorise (details of previous practice):

Dr....., of

Practice name….....

Address.....

.....Post code ….....

Telephone.....Fax.....

To release my dental records or copies thereof (including clinical notes, xrays and photographs) and (if applicable) those of my dependants:

1).....

2).....

3).....

4).....

And to provide such records to **SALAMANCA DENTAL**

L4 18A 33 Salamanca Place
Battery Point TAS 7004
Phone 62888070
Email: admin@salamancadental.com.au

Patient Signature..... Date.....