Request and authorisation for release of dental records

Patient details

Patient name: D.O.B: / /

Residential address:

Suburb: Postcode: State:

I hereby express written consent and request that all my dental and medical records be released from

to Claremont Family Dental in time for an upcoming appointment with the practice.

Appointment date:

Please forward copies of these records via email to info@claremontfamilydental.com.au or by registered mail, courier or personal delivery.

To: of:

Claremont Family Dental
247 Stirling Highway
Claremont WA 6010

Digital photographs or radiographs can be emailed to info@claremontfamilydental.com.au.

Copies of the following are specifically requested:

- Medical history forms
- Progress notes
- Letters and reports to/from specialists
- Periodontal charting
- Radiographs

If there are any queries, please contact Claremont Family Dental, Claremont on (08) 9385 2418.

Kindest regards,

Signature

Patient name: Signature: Date:

Parent/guardian signature (if applicable):