Queen Street Dental

AUSTRALIAN DENTAL ASSOCIATION

Experience Care

Patient Authority to Release Dental Records

I, _____, hereby authorise my previous treating dentist

Dr _____of _____to release

my dental records or copies thereof (including radiographs and photographs where

applicable) (if applicable) and those of my dependants:

_____ _____

_____ _____

And provide such records by registered mail, courier or email to

Dr Greg Morton
_____ (requesting dentist) of

Queen Street Dental
Level 5/300 Queen Street
Brisbane QLD 4000
Ph: (07) 3221 6427
Email: reception@queenstreetdental.com

Signed Date

_____ _____

Name: _____

D.O.B: _____

Address: _____

_____

_____

Phone: _____