# Patient Authority to Release Dental Records

I …….hereby authorise Dr …… ……of (address)

……

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

(if applicable) and those of my following dependants

…….

And provide such records to:

Dr …… ……

Kenmore Dental Centre
11/2081 Moggill Road
Kenmore Q 4069
Ph: (07) 3878 1020
Fax: (07) 3878 3342
Email: reception@kenmoredentalcentre.com.au

I understand that the release of these confidential records is at the discretion of the treating dentist, Dr …… ……... and that the original records remain the property of the dentist that created them.

Signed:…….

Name: (in full) …….

Date of birth: ……...

Address: ……..

……..

Telephone: …….....

Date: ……...