Patient Authority to Release Dental Records

I, (your full name) :

hereby authorise (previous dentist name):

of (address):

to release my dental records or copies thereof (including radiographs and photographs where applicable) and those of my following dependants (if applicable):

Dependent 1:

Dependent 2:

Others Dependents:

And to provide such records to:

Dr Vu Ngo of **PVB Dental, 74 High Street, North Rockhampton. QLD 4701**

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

Your Name:

Your Address:

Phone Number:

Date:

Signature: