40/230 Napper Road
Arundel QLD 4214
Ph: 07 5563 3133
Fax: 07 5563 3122

# Patient Authority to Release Dental Records

I _____ hereby authorise, _____
(Name of Dentist/ Specialist Practice Name)

_____

To release my dental records or copies thereof (including radiographs)

And those of my following dependants (if applicable):

_____

_____

_____

And to provide such record to:

**Dr Chris Waters**

Of (address) 40/230 Napper Road Arundel QLD 4214

I understand that the release of these confidential records is at the discretion of treating dentist

Dr_____

and that the original records remain property of the dentist who created them.

Signed: _____

Name (in full) _____

Date of Birth: _____

Phone: _____

Date: _____