Bite dental studios

Patient Authority to Release Dental Records

Click on form fields below & type to edit

I, (name) First name, Surname

hereby authorise Dr Name of previous Dentist

of (address) Address of previous Dentist

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

and those of my following dependants (if applicable)

Full name of dependant 1

Full name of dependant 2

Full name/s of any other dependants (if applicable)

And to provide such records to:

Dr Simon Franks

of **Bite Dental Studios, Level 17, 141 Queen St Brisbane 4000**

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.

Name Name in Full

Address Number, Street

Suburb

Postcode

Phone Best contact number

Dated 1 January 2011

(signature) **Click to print and sign document**

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Simon Franks Dental Pty Ltd TA Bite Dental Studios ABN 92 130 682 754

Copy for treating Dentist

Copy for Dentist requiring records

Copy for Patient

Nov 2010