

PATIENT AUTHORITY TO RELEASE DENTAL RECORDS

Ihereby authorise

Dr

of (address)

.....

Phone:..... Fax:.....

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

Dr Charlotte de Courcey-Bayley BDS (Hons) Sydney University
Holistic Dental Care
PO Box 233
St Leonards
NSW 1590

FAX: (02) 9436 1289
PHONE: (02) 9439 2090
EMAIL: info@holisticdentist.com.au

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

Signed

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Your Name (in full):

Your Address:

.....

.....

Phone:

Date: