

Request and Authorisation for Release of Dental Records

(Insert name of dental practice with any prior records)

To: Dr. _____ of

I (patient/parent/guardian) , _____ hereby express written consent and request the release of dental records for:

Patient's name: _____ Date of Birth: _____

Please forward copies of these records to current dental practice (**Better Teeth Dental Care**):

Email (preferable): reception@betterteeth.com.au

Postal: 177A Concord Road, North Strathfield NSW 2137

Copies of the following are specifically requested:

- Progress notes
- Letters/reports to/from specialists
- Radiographs
- Periodontal charting

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

Patient/Parent/Guardian signature: _____ Dated _____

Printed name: _____

Telephone contact: _____

If there are any queries, please contact Better Teeth Dental Care on **(02) 8765 1818**.