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**Authorisation for release of dental records and x-rays**

To: .....  
.....(Dental Practice/Surgeon)

I .....(patient or guardian name) DOB: .....  
of .....  
.....(address)

Hereby authorize any dentist, medical practitioner or hospital that has records or knowledge concerning my dental health release all such records to:

Canberra Dental Care

3/33 Allara St Canberra ACT 2601

Email: [contact@canberradental.com.au](mailto:contact@canberradental.com.au)

I specifically request that you release copies of:

- All treatment notes
- All x-rays including panoramic

Signed (patient or guardian name): .....

Printed name: .....

Date: .....