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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

I specifically request that you release copies of:

- All treatment notes
- All x-rays including panoramic

Signed (patient or guardian name):

Printed name:

Date: