



samuel street dental practice
39 Samuel st
Camp Hill, 4152
(07) 3398 1750
www.samuelstreetdental.com.au

Patient Authority to Release Dental Records

Release

I, _____ hereby authorise
Dr _____
of (address) _____
to release my dental records or copies thereof
(including X-rays and photographs if applicable)

and those of following dependents(if applicable)

And to provide such records to

Dr Claude Capelli
39 Samuel St.,
Camp Hill, QLD., 4152

I UNDERSTAND THAT THE RELEASE OF THESE CONFIDENTIAL RECORDS IS AT THE D
OF THE PREVIOUS TREATING DENTIST DR _____
And THAT THE ORIGINAL RECORDS REMAIN THE PROPERTY OF
THE DENTIST WHO CREATED THEM.

Signed _____

Dated: _____

Name of Patient (in full) : _____

Address: _____

Telephone: _____

DISCRETION