ARTHUR STREET Dental

phone 02 6652 1677 | fax 02 6652 4745
address 3/14 Arthur Street (North Entrance Plaza) Coffs Harbour NSW 2450
email reception@arthurstreetdental.com.au | web arthurstreetdental.com.au

Dental Records Request and Authorization Form

Date: / /

To:.....

.....

Dear.....

Records Requested For:

☐ Myself

☐ Family Member(s) (Please list below)

I respectfully request the release of my clinical notes and any radiographic images (X-rays), including those pertaining to the family members listed below

Please forward a copy of all requested records to:

3/14 Arthur Street, COFFS HARBOUR NSW 2450 or email to:

reception@arthurstreetdental.com.au

Name:.....DOB: ...../...../.....

Name:.....DOB: ...../...../.....

Name:.....DOB: ...../...../.....

Name:.....DOB: ...../...../.....

The patient is attending our practice for treatment and has requested the transfer of their previous dental records to support the continuity of their care with us.

I hereby authorize the release of my dental records to Arthur Street Dental.

Signature:.....

Date: / /