Sunshine Dental Group
Your friendly family dentist

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DENTAL RECORDS AND RADIOGRAPHS RELEASE REQUEST FORM

I (patient's name) ____

of (patient's address) ____

D.O.B________________

in the State of Victoria, hereby authorise and direct   to obtain any information relating to my dental treatment and any radiographs/OPG/photographs from Practice/Institution

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I understand that release of these confidential records is at the discretion of the treating dentist and that the original records remain the property of the dentist/practice.

Signed ______________________________________

Name (in full) ________________________________

Date ________________