Date:

I, _____, hereby

authorize my previous treating dentist Dr _____,

from _____ to release a copy of my dental records

including radiographs & photographs where applicable.

(if applicable) and those of my following dependents

_____

_____

_____

And to provide such records by email, registered mail, courier or personal delivery to

Dentist _____
SV Dental Sun Valley
8/85 Sun Valley Road
Kin Kora QLD 4680
reception@sunvalleydental.com.au

Patient: _____

DOB: _____

Address: _____

Phone: _____

Kind regards,

_____ Signature