GOODLIFE DENTAL STUDIO

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PATIENT AUTHORITY TO RELEASE DENTAL RECORDS

NAME: _____ DOB: ____/____/____

I hereby authorize the release of my dental records and radiographs, and that of my dependents as listed below (if applicable):

NAME: _____ DOB: ____/____/____

NAME: _____ DOB: ____/____/____

NAME: _____ DOB: ____/____/____

I would like these records to be released and:

O Sent to 'Goodlife Dental Studio Pty Ltd' via email to info@goodlifedentalstudio.com.au

O Sent to myself via email to _____

O Personally collected by myself from your dental office

O Sent to _____

_____

I understand that the release of these confidential records is at the discretion of the treating dentist and that the original records remain the property of the dentist who created them.

SIGNED: _____ DATE: ____/____/____