RECORDS RELEASE

PATIENT

Title _____ First Name _____ Surname _____

Address _____

Postcode _____ State _____ Date of Birth _____

Contact Number _____ Email _____

REQUEST FROM

Person requesting the patient records (if not the patient)

First name _____ Surname _____

Address _____

Postcode _____ State _____ Relationship to Patient _____

Contact Number _____ Email _____

PROVIDED BY

The patient records are to be provided by:

☐ Post (to patient or other applicable person requesting access)

☐ Email (to patient or other applicable person requesting access)

☐ Another Person or Practice (Please provide details to the right)

Name _____

Address: _____

Postcode _____ State _____

Email: _____

DECLARATION

I _____ request the release of: *(Tick applicable)* ☐ my dental records, ☐ my X-Rays only,

☐ the dental records of _____ of whom I am ☐ the parent ☐ the legal guardian.

I confirm that I have provided the correct contact details for the Recipient.

I understand I do not own my dental records according to the Office of the Australian Information Commissioner and the practice is providing copies of my dental records to assist me in the provision of ongoing future dental care.

If I have requested that the practice transfer the patient records by email:

- I acknowledge that email transmission cannot be guaranteed to be secure or error-free
- I acknowledge that information could be intercepted, corrupted, lost, destroyed, arrive late or incomplete
- I release the practice from all liability relating to any data breach associated with the transmission of the records by email across the internet or the security of the Recipient's email account
- I can ask for the records to be provided to me personally or by mail if I am sufficiently concerned about email security

Signature: _____ Date: _____

RECORDS RELEASE

OFFICE USE ONLY

DENTAL PRACTICE

Practice Name _____ Treating Dentist _____

Practice Address _____

Postcode _____ State _____ Contact _____

Identification Sighted

- ☐ Passport
- ☐ Driver's Licence
- ☐ Other (Please Specify) _____

Name of Practice Representative Releasing Records _____

Signature _____ Date of release _____