Pacific periodontics & implants®

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REGISTERED DENTAL SPECIALISTS

PATIENT AUTHORITY TO RELEASE AND OBTAIN DENTAL AND MEDICAL RECORDS

I, _____ hereby authorise my initial medical and dental practitioner to release my dental and medical records or copies thereof (including radiographs and photographs where applicable).

(If applicable) and those of my following dependants.

_____

And to provide such records to **Pacific Periodontics and Implants** Suite 1/419 Golden Four Drive Tugun 4224. **Ph: (07) 55595911**

Please email information to: **info@pacificperio.com.au**

I also authorise the Pacific Periodontics staff to send copies of my dental records to my regular medical and dental practitioners and other relevant health care practitioners.

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

SIGNED: _____

NAME (in full): _____

ADDRESS: _____

_____

D.O.B: _____

TELEPHONE: _____

DATED: _____

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