# Patient Authority to Release Dental Records

**I, ……., hereby authorise my previous treating dentist Dr**
**of to release my dental records or copies thereof**
**(including radiographs and photographs where applicable)**

**(if applicable) and those of my dependants:**

**…….**
**…….**
**…….**

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

○ **Dr Greg Morton** ○ **Dr Nick Cusack** ○ **Dr Alexandra Coombs**

**of (address)** **Queen Street Dental**
**5/300 Queen Street**
**Brisbane, QLD 4000.**
**Ph: 07 3221 6427**
**Email: reception@queenstreetdental.com**

**Signed**

**…….**

**Name (in full):**

**D.O.B:**

**Address:**

**Telephone:**

**Date:**