



**818 Dental**  
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**PATIENT AUTHORITY TO RELEASE DENTAL RECORDS**

**Patient Details** \_\_\_\_\_  
**Address** \_\_\_\_\_  
**Phone** \_\_\_\_\_  
**Date of Birth** \_\_\_\_\_

I hereby authorise my previous treating dentist: \_\_\_\_\_  
of (address) \_\_\_\_\_  
\_\_\_\_\_

to release my dental records or copies there of (including radiographs and photographs where applicable) and to provide such records to 818 Dental.

Please email to: **reception@818dental.com.au**

**Signature** \_\_\_\_\_  
**Name** \_\_\_\_\_  
*Please Print*  
**Date** \_\_\_\_\_

*Please also include my following family members (if applicable)*

1. Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_
2. Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_
3. Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_
4. Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_