AUTHORIZATION FOR RELEASE OF DENTAL RECORDS AND RADIOGRAPHS

I,(patient's name) _____of (residential address) _____ _____,

hereby authorize transfer of all my dental records, including radiographs and copies of treatment notes from your practice

To:

Dr Tijana Fisher/Dr Catherine Anne Walsh
The Dentist at 70 Pitt Street
Level 1, 70 Pitt Street
Sydney 2000
Ph: 02 9232 6367
info@thedentist.net.au

Signed by patient: _____

Date: _____