Essendon Dental Group
167 Buckley Street
Essendon Vic 3040
tel (03) 9337 5589
fax (03) 9331 2358
reception@essendondg.com.au

PATIENT AUTHORITY TO TRANSFER RECORDS FROM ANOTHER PRACTICE

In providing the most appropriate dental treatment for you in our practice, we believe it would be of great assistance to access information about your previous treatment. To ensure compliance with the Federal and State Privacy Legislation, we require your signed consent to authorise access to these records.

Please be aware that it is lawful for a practitioner to charge fees to a patient requesting access to, and copies of, written records and other forms of diagnostic records.

I, (patient) _____ Date of birth _____/_____/_____

hereby authorise my previous treating dentist Dr _____

of (address) _____

_____

_____

to release my dental records or copies thereof (including radiographs and photographs). And those of my following dependants (if applicable)

_____

And to provide such records to Dr _____ (requesting dentist)

of Essendon Dental Group

Email: reception@essendondg.com.au

Fax: (03) 9331 2358

Address: 167 Buckley Street, Essendon, VIC 3040.

Name of person authorised to sign for patient: _____

Address: _____

Signature: _____

Date: _____/_____/_____