



REQUEST FOR RELEASE OF DENTAL RECORDS

I of
(insert patient name) *(insert address)*

request a copy of:

- my dental records / a summary of my dental records.
- my child's /children's dental records/
(insert children's name/s)
a summary of my child's/ children's dental records.

be released by to
(insert practice name)

- Me
- My treating dental practitioner
(insert dentist name)

I wish a copy of the records to be

- Given to me personally.
- Posted to me at the following address by Express Post and marked personal and confidential
(insert postal address)
- Posted to my treating dental practitioner at
(insert dentist name)
.....
(insert practice postal address)
- Emailed to me at.....
(insert email address)
- Emailed to my treating dental practitioner at
(insert dentist name)
.....
(insert practice email address)

In requesting a copy of the records, I understand that;

- the records will be emailed/posted to my nominated address,
- receiving by email may not be as secure as receiving the records personally or by post,
- the practice accepts no liability for the records once they leave the practice,
- the practice accepts no liability for the records if they are accessed by unauthorised persons during transit or in any manner whatsoever without limitation,
- I can ask for the copy of the records to be provided to me personally or by post if I am sufficiently concerned about email security,
- I will acknowledge receipt of the records once received.

Signed Date
(patient signature)

Previous Practice - Office use only

Records were:

- posted - Reference Number:
(consignment / registered post)
- emailed
- hand delivered by:
(insert name)

Signed: on
(signature of previous Dentist or Practice Manager) *(insert date)*

Requesting Practice – Office Use only

Records Received: on.....
(signature of requesting Dentist or Practice Manager) *(insert date)*