**AUTHORIZATION FOR RELEASE OF DENTAL RECORDS**

 I, (patient’s name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

of (residential address) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Dr Brett Taylor, Leading Edge Dental

16 The Strand Penshurst 2222

E: mail@edgedent.com.au

T: 9580 3047

Signed by patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_