**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](mailto:mail@edgedent.com.au)

T: 9580 3047

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