Patient Authority to Release Dental Records to LARA dental

I,

hereby authorise Dr

of (address)

to release my dental records or copies thereof (including radiographs where applicable)

and also those of my following dependents (if applicable)

D.O.B

D.O.B

D.O.B

D.O.B

and to provide such records to Dr

of LARA dental, 14 Forest Rd South, Lara VIC 3212, email: frontoffice@laradental.com.au

I understand that the release of these confidential records is at the discretion of Dr

and that the original records remain the property of the dentist who created them.

Name

Address

D.O.B

Date

Signed