



Kawana Dental

Dr Mark Maltby *Dr Leanne Paterson*
Dr Tamara Warren *Dr Tim Chin*
Dr Dan Eastcott *Dr Martha Ponce*
Dr Murray Hayes *Dr Aninda Dey*
Dr Michael Maltby *Dr Patricia Morrison*

PATIENT AUTHORITY TO RELEASE DENTAL RECORDS

I, _____ D.O.B _____ of (address) _____

hereby request my previous treating dentist, Dr _____
of (practice name) _____

to forward my dental records or copies thereof, (including radiographs where applicable)
and those of my following dependents:

I wish a copy of the records to be:

- Emailed to my treating dentist
- Posted to my treating dentist

To ensure our patients' data security, please supply clinical records and radiographs by
registered mail or secure email to:

Email: info@kawanadental.com
Address: Kawana Professional Centre
134a Pt Cartwright Drive
Buddina Qld 4575
Ph: **07 5444 7111**

SIGNED: _____

DATED: _____

THANK YOU FOR YOUR ASSISTANCE