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) _____

(practice phone number) _____

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

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