



Kawana Dental
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info@kawanadental.com

Dr Mark Maltby	Dr Tamara Warren
Dr Tim Chin	Dr Aninda Dey
Dr Martha Ponce	Dr Trish Morrison
Dr Dan Eastcott	Dr Murray Hayes
Dr Leanne Paterson	Dr Nancy Henein

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