Laser + Holistic Dental

Dental Records Release Form

Please fill out the information below if you would like your dental records sourced from your previous dental clinic:

Previous Dental Clinic's Name: ____

Patient's Name: ____________________________________ Date of Birth: _dd_/_mm_/_yy_

Please provide the details for your previous dental clinic for us to communicate with on your behalf.

Contact Number: _(____)________________________ Fax Number: _(____)________________________

This is a request to have dental records and radiographs released to Laser + Holistic Dental, South Yarra.

In order to comply with State & Federal Privacy Legislation, the patient's signed consent is provided below.

I ________________________________ consent to have my dental records and radiographs released to Laser + Holistic Dental, South Yarra.

Signature: ________________________________ Date: _dd_/_mm_/_yyyy_

Thank you for your assistance. If you have any queries in regards to this request please contact Laser + Holistic Dental.

To maximise the security of patient confidentiality we request patient records be emailed to: info@laserandholisticdental.com

Laser + Holistic Dental

A partner of 2nrich Wellness Centre

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