AUTHORITY FOR TRANSFER OF DENTAL PATIENT RECORDS

Dear…….. …….

(Patient's name)

In providing the most appropriate dental treatment for you in our practice, we believe it would be of great assistance to access information about your previous treatment from

Dr…….

(Previous dentists name)

To ensure compliance with the Federal and State Privacy Legislation, we require your signed consent to authorise access to these records.

Please be aware that it is lawful for a practitioner to charge fees to a patient requesting access to, and copies of, written records and other forms of diagnostic records, such as radiographs etc. Any accounts which may be issued for these purposes will require your payment.

Patient consent:

I give permission for Dr ……to seek copies of my dental records from :

Dr…….

(Previous dentist)

I agree to pay any fees incurred in the copying process, as defined in the Privacy Regulations.

Patient details:

Name:
D.O.B:
Address:
Date:
Signature:

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