FORM OF AUTHORITY REQUESTING RECORDS

Date requested:

Clinic requesting records **from** _____

_____

_____

_____

To whom it may concern

RE: Patient Records

It would be greatly appreciated if you could provide a copy of records, radiographs and treatment details for;

Patient Details

Name: _____

Address: _____

_____

DOB: _____

Patient Signature: _____

Yours sincerely,

Dental Sense
2 Mellar Court
MIDLAND WA 6056
Ph: 9250 8844
Fax: 9250 2265
Email: dentists@dentalsense.com.au