Belmont Dental Surgery

Dr Mathew Kurian BDS (Uni. of Syd)

Patient Authority to Release Dental Records

I ……herby authorise

……. of

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to release my dental records or copies of thereof (including radiographs and photographs where applicable which will be returned) and those of my following dependants :

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and provide them to Belmont Dental Surgery.

Signed

……

Name……

D.O.B.:- ……..

Address……

…….

Telephone:……

479 Pacific Highway
Belmont NSW 2280
P: (02) 4945 0800
F: (02) 4945 0876
Email: reception@belmontdentalsurgery.com.au