



Instructions for Patient Authority to Release Dental Records

INSTRUCTIONS FOR PRACTITIONERS

Please read these instructions thoroughly to comply with the Privacy Legislation before using the form overleaf

1. Have the **patient fill in Section A**. Send that form by **general post, or fax or email**
2. **The Releasing dentist fills in Section B at or after delivery / dispatch**
3. **The releasing dentist Makes three copies** - one for the patient to keep after all sections have been filled in, and **two** for the requesting dentist.
4. **The ORIGINAL is retained** with sections A and B filled out by the releasing dentist
5. The records (copies not originals) and the **two copies of the form (with A and B filled in)** are then sent by either Registered Mail, Courier or hand delivery **NOT by General Post** to the requesting dentist
6. The **Requesting dentist** fills in **section C on both copies** and sends one back (ordinary mail) to the releasing dentist (except if the records are hand delivered in which case a signature ought to be obtained at delivery)

As a result

- The patient has **one copy** with section A filled in
- The requesting dentist has a copy with **all sections** filled in
- The releasing dentist has **one original with sections A and B filled in and copy from the requesting dentist with all sections filled in**

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Patient Authority to Release Dental Records

SECTION A

I,(patient), hereby authorise my previous treating dentist
Dr, of (address)..... to release
my dental records or copies thereof (*including radiographs and photographs where applicable*)

(if applicable) and those of my following dependants

.....
.....
.....

And to provide such records by **registered mail, courier or personal delivery** to

Dr, (requesting dentist)
of (address)

.....
.....

Signed

.....

Name: (in full)

Address:

.....
.....

Telephone:

Dated:

SECTION B

Records were (registered) mailed/ couriered on (Date)

Consignment Number or Registered Mail Reference Number.....

OR

Hand Delivered by.....(name) on date

.....
Signed Name

SECTION C

Records Received : (Name and Signature of requesting dentist or agent)