DIMOS DENTAL
& FACIAL AESTHETICS

Authorisation to release confidential patient information

I, _____ request and authorise
Patient or Guardian Name

_____to disclose and provide
Practice or dentist name

copies of any and all clinical treatment records and information regarding my care, which is in the possession of this person or entity, to:

Dimos Dental_____
Name of new Dentist/ Practice

Level 7, 379 Collins Street_____
Address

MELBOURNE_____VIC_____3000_____
City State Postcode

These records include, but are not limited to: personal patient information, medical and dental histories, examination records, radiographs, clinical photographs, treatment records.

Printed Name: _____

Signed: _____ Date: _____
Patient or Guardian

Suite 2, Level 7, 379 Collins Street, Melbourne VIC 3000
Tel: (03) 9654 6667
Fax: (03) 9654 6621
Email: mail@dimosdental.com.au
Website: www.dimosdental.com.au