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& implant dentistry
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RELEASE OF RECORDS

Please complete all sections of this form to give permission for Affinity Periodontics & Implant Dentistry to request your dental records from an external dental provider.

Patient Details

I, _____ **of** _____

Phone: _____ **Email** _____

Date of Birth: ____/____/____ authorise and request the release of dental records.

☐ My dental records **OR**

☐ A child: _____ of whom I am the parent ☐ **OR** legal guardian ☐

I request the records are to be transferred by:

☐ Email to Affinity Periodontics & Implant Dentistry – **reception@affinityperio.com.au**

☐ To be sent to Affinity Periodontics & Implant Dentistry, 97 Union Road, Ascot Vale Vic 3032

☐ To be collected at the practice by me.

Dental Practice Details

Dentist Name: _____

Practice Name: _____

Practice Address: _____

Practice Email: _____ **Practice Phone:** _____

Declaration

☐ I confirm that the details I have provided on this form are correct.

☐ I have the legal right to access the dental records of the above patient.

☐ If I have requested the transfer of my records by email:

- I acknowledge that email transfer is not guaranteed to be secure or free of errors and can be intercepted, corrupted, lost, destroyed, arrive late or incomplete
- I release the practice from all liability relating to any data breach associated with the transmission of records by email or the security of the email account.

In the interest of your privacy and to ensure we are compliant with the *Commonwealth Privacy Act (1988)* and the Australian Privacy Principles, we will not request or release any of your personal details, which includes your dental records, without explicit approval from you.

Signed: _____ **Date:** _____