



## Records Request Form

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

I, \_\_\_\_\_ of \_\_\_\_\_

Date of birth: \_\_\_/\_\_\_/\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_

authorise and request the release of my dental records to be transferred to Affinity Periodontics and Implant Dentistry by:

- email,
- posted to Affinity Periodontics and Implant Dentistry, 108/272 Barkly St Brunswick Vic 3056
- or 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: \_\_\_\_\_