SA Dental

Government of South Australia

SA Dental clinic contact details

## AUTHORITY FOR SA DENTAL TO ACCESS PERSONAL &/OR TREATMENT INFORMATION

**CLIENT DETAILS** (Please print clearly)

**Full Name** .....

**Address** .....

**Date of birth** ..... **Phone** .....

**Previous name** (including previous married name, previously known as, a shortened version of your name or a different spelling)

.....

**Previous address** .....

**INFORMATION REQUIRED**

**Records required are** .....

**Dating from** ..... **to** .....

**Radiographs required** Yes ☐ No ☐ (If yes and only originals available, SA Dental will ensure their return)

**A summary of examination(s) &/or treatment provided is sufficient** Yes ☐ No ☐

**AUTHORITY** (Delete which is not necessary)

**I** ..... **OR**
(Name)

**I** ..... **as** ..... **of the above**
(Name) (E.g. relative, carer, guardian, in loco parentis, advocate, Power of Attorney)

authorise SA Dental to access copies of and discuss information, records & radiographs about my / the above named person's (delete that which is not relevant) examination(s) &/or treatment.

**Signature** ..... **Date** .....

This consent will expire in 3 months from this date.

**CLINIC TO KEEP COPY**

V1_Feb 2024