SA Dental

Government of South Australia

SA Dental clinic contact details

AUTHORITY FOR SA DENTAL TO RELEASE PERSONAL &/OR TREATMENT INFORMATION

CLIENT DETAILS (Please print clearly)

Full Name ..... **Date of birth** .....

Address .....

Phone ..... **UR number** (if known) .....

Previous name when seen by SA Dental (including previous married name, previously known as, a shortened version of your name or a different spelling)

Not applicable ☐ **Yes** ☐ (Please provide) .....

Previous residential address when seen by SA Dental (address history may be required to locate all of your records)

Same as current ☐ **Other** ☐ (Please provide) .....

PROVIDER DETAILS

Name of provider seeking information .....

Address .....

INFORMATION REQUIRED

What records are required .....

From (Name of SA Dental clinic / clinics) .....

How far back do you want the records to go? .....

Are copies of radiographs required? No ☐ Yes ☐ Which ones? .....

NOTE: Radiographs which are two years or older will only be provided if specifically requested. Radiographs will be provided electronically when available in digital format. Where analogue radiographs exist, there will be a delay of up to 15 working days in forwarding the records to allow time for obtaining the required copies. If client records are emailed, they will be encrypted – SA Dental cannot guarantee transmission security.

Are copies of study models required? Yes ☐ No ☐

Will a summary of the dental treatment provided be 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. **This consent will expire in 3 months from this date.**

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

RETURN COMPLETED FORM TO RELEVANT SA DENTAL CLINIC