Government of South Australia

SA Health

SA Dental Service Clinic Contact Details

# Authority for SA Dental Service to access personal &/or treatment information

***Client Details*** *(please print clearly)*

Full name ..........................................................................................................................

Address ……...........................................................................................................................

Date of Birth ………………………………….  Ph …….…………..……….………….....

***Information required***

Records required are……………………………………………………………………………..

Dating from ……………………….. to …………………………..

Radiographs required? Yes ❑ No ❑

*(If yes and only originals can be provided, SA Dental Service will ensure their return)*

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

***Authority*** *(delete that which is not relevant)*

I …………………………………………………………… ***OR***

*name*

I …………………………………………………… as ……….……………………………..…of the above

*name* *(eg relative, carer, guardian, in loco parentis, advocate, Power of Attorney)*

authorise SA Dental Service 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**