Government of South Australia
SA Health

SA Dental Service Clinic Contact Details

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

Client Details *(please print clearly)*

Full name ……………………………………………………………………………………..……………………

Address……...

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

UR # / Clinic ……………………………………………………………………………..……………..….

Provider Details

Name of provider seeking information ………………………………………………………………….

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

Information required

What records are required? ……………………………………………………………………...……

From which clinic(s)? ……………………………………………………………………………...…….

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

Are copies of radiographs required? Yes ❑ No ❑ Which ones? ………………………..…......

NOTE: If copies of radiographs are required, be aware there will be a delay of up to 10 working days in forwarding the records to allow time for obtaining the required copies. Radiographs which are two years or older will only be copied if specifically requested.

Are copies of study models required? Yes ❑ No ❑

Will a summary of the dental treatment provided be 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 release 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***

Return completed form to relevant SA Dental Service clinic

Last updated Oct13