



## Request for Copies of Documents or Access to Your Dental Records

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### REQUEST TO ACCESS DENTAL RECORDS

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

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request copies of the documents listed on the attachment and/or to view my dental record.

I understand that a fee may be payable for copies of documents and/or attendance by a dentist when I view my dental record. I understand that I will not be permitted to remove the contents of my dental record from the premises of the dental practice, nor will I be permitted to alter, or erase information contained in the dental record.

(Tick as appropriate)

Please send the copies of the documents to me.

I request that the copies of documents I have requested be provided to the following person authorized by me:

Name \_\_\_\_\_

Address \_\_\_\_\_

Signature of Patient: \_\_\_\_\_

Date \_\_\_\_\_