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** ..........................................................................................................

## PRIVATE PROVIDER DETAILS

SA Dental seeks access to records of the above client, held by the following practitioner/clinic:

**Name** ..........................................................................................................

**Practice Name** ..........................................................................................................

**Address** ..........................................................................................................

**Phone** ................................................ **Email** ..................................................

## 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 ☐

Please send record copies via email to: ................................................(SA Dental clinic email address)

**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)

**Sent to private practice on** ................................................ **by** ..................................................
(Date) (SA Dental staff member)

**(Clinic to save completed copy of form to Titanium, then forward to private practice for action)**