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RECORD RELEASE CONSENT FORM

In accordance with the Privacy Act 2000, your written consent must be obtained before confidential information contained in your dental records may be released to another party.

Your privacy is important to us. The privacy act contains a set of principals for handling personal information in a confidential and secure manner.
We will only release your personal information to other **Health care providers** *for care and continuation of your Orthodontic treatment, while you are being treated with us.*

I,____ for ____________________________

Of___ No:____________ Street:____

____
Suburb: Postcode:

Date of Birth ______________________________

I do/do not consent to the release of my/my child’s (if under 16yrs of age) dental records to my /my child’s dental practitioner / dental specialists/ medical practitioner, during the time being treated by Ipswich Orthodontics.

Signature ______________________________ (Relationship if child is under 16 years of age)

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Date___________________________________

This form must be signed prior to our practice releasing records.