FAMILY DENTAL CARE

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REQUEST TO ACCESS DENTAL RECORDS

Date: _____

I, _____(name) of _____(address)

request access to my dental records **or** give consent to _____ (authorised person) access, the following documents (see 'Form A').

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 records.

I understand that I will be permitted to obtain copies of the contents of my dental records. Where copies are requested, a reasonable fee may be applicable to cover administrative costs. Further, I understand that copies will be available to me as soon as practicable, but within 30 days of the date of the practice receiving this application.

Patient Date of birth: ……..

Type of Patient ID: ……..

Patient Signature:……

If **authorised person**:

Name:……

Address:……

Date of Birth: ……..

Type of ID: ……..

Signature:……

Form A

Please indicate which records are requested:

1. Written Records
   - □ All
   - □ From _____to_____
2. Radiographs (x-rays)
   - □ All
   - □ From _____to_____
3. Specialist reports
   - □ All
   - □ From _____to_____

Other:

4. _____
5. _____
6. _____
7. _____
8. _____

How would you like the information conveyed to you?

- □ verbally (do you want the dentist to read them to you in 'plain language'?)
- □ visually (do you want to see the original copy?)
- □ Copy
  - □ Hard copy, i.e. paper copies
  - □ Soft copy, i.e. electronic copy on USB or CD
  - □ Email ……
- □ Directly to another dentist via email
  - Dentist's name ……
  - Practice name ……
  - Telephone number ……
  - Email address ……