

# **STIRLING FAMILY DENTAL**

**7 Druid Avenue, Stirling. 5152**

**Phone 8339 1836 Fax – 08 8490 2311**

**Email – [records@stirlingfamilydental.com.au](mailto:records@stirlingfamilydental.com.au)**

## Dental Records Release Form

Name and address of patient records to Transfer:

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Date of Birth: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Other Family Members to Transfer: \_\_\_\_\_

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**Previous Dentist or Practice Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

Please forward any of the following information that you have: x-rays, patients records, and photographs to Stirling Family Dental

### **PLEASE EMAIL DIGITAL RADIOGRAPHS/IMAGES**

I hereby give you permission to release any and all of my dental records to Stirling Family Dental

Patient Signature (parent if a minor) .....Date .....

If records are digital, please e-mail to:  
[records@stirlingfamilydental.com.au](mailto:records@stirlingfamilydental.com.au)

Or mail to:  
Stirling Family Dental  
7 Druids Avenue,  
Stirling. SA 5152