

# STIRLING FAMILY DENTAL

26 Mount Barker Road, Stirling SA 5152  
(08) 8339 1836      [info@stirlingfamilydental.com.au](mailto:info@stirlingfamilydental.com.au)

## Dental Records Release Form To Patients

Patient Name and Address to Transfer:

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

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

Email: \_\_\_\_\_

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

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Previous Dentist/Practice Name:

Previous Practice Address:

Previous Practice Phone Number:

Please forward any of the following information that you have: x-rays, patient records, and photographs to myself or listed family member.

I hereby authorise permission to release any and all of my dental records to myself or listed family member.

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

Date .....

If records are digital, please email to:  
[info@stirlingfamilydental.com.au](mailto:info@stirlingfamilydental.com.au)

Or mail to:  
Stirling Family Dental  
26 Mt Barker Road  
STIRLING SA 5152