**Hume Dental Group**
1 Katryn Street, Fawkner Vic 3060
03 93574477
info@hume.dental
ABN: 90 109 826 066

**Dental Records Request Form**

*(Please complete with three patient identifiers: Full Name, Date of Birth, and Contact Number/Address)*

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**Patient Full Name:** _____
**Date of Birth:** _____
**Phone Number:** _____
**Address:** _____

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**Records Requested**

Please specify the records you are requesting:
☐ Full dental records
☐ Treatment notes
☐ X-rays / Radiographs
☐ Referral letters
☐ Invoices / Payment history
☐ Other (please specify): _____

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**Purpose of Request**

☐ Personal copy
☐ Transfer to another dental clinic
☐ Insurance / legal purposes
☐ Other: _____

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**Recipient Details (if being sent to another provider)**

**Clinic/Provider Name:** _____
**Address / Email:** _____

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**Patient Consent**

I authorise **Hume Dental Group** to release the dental records indicated above to myself or the provider listed. I understand that:

- Records will be provided in accordance with privacy and health record legislation.
- Processing may take up to **5–10 business days**.
- X-rays may only be provided electronically unless otherwise arranged.

**Patient Signature: _____ Date: _____**

**Staff Member (Received By): _____ Date: _____**