Medical Record Authority

I authorise the release of all documents and information comprising my medical records including but not limited to clinical notes, comments, photographs, diagrams, x-rays and reports in your possession to Queensland Maxillofacial Group of Suite 1 / 8 Vine Street, Greenslopes. I further authorise Queensland Maxillofacial Group to contact any and all of my medical providers to discuss my medical records and care.

____________________ ______________

Signed Date

To be completed by parents or guardians for patients under the age of 16;

I, ______________________, parent/guardian of ________________________ (the child) authorise the release of all documents and information comprising the child's medical records including but not limited to clinical notes, comments, photographs, diagrams, x-rays and reports in your possession to Queensland Maxillofacial Group of Suite 1 / 8 Vine Street, Greenslopes. I further authorise Queensland Maxillofacial Group to contact any and all of the child's medical providers to discuss the child's medical records and care.

____________________ ______________

Signed Date