

# Records Request Form

*Privacy Amendment (Public Sector) Act 2000*

Dental Surgeons:

**Michael Whitford** B.D.S.

**Han Oh** B.D.Sc. (WA), Grad Dip  
Clin Dent (Oral Implants) (Syd)

## Patient Details

First Name \_\_\_\_\_

Surname \_\_\_\_\_

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

I hereby authorise **Central Leederville Dental** to request all health records, including x-rays, on my behalf, from:

Practice Name \_\_\_\_\_

Address \_\_\_\_\_

Email Address \_\_\_\_\_

Additional remarks \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please send all digital records and images to [reception@centralleedervilledental.com](mailto:reception@centralleedervilledental.com)

Please send all hard copies to  
Suite 6, Delwyn Court  
643 Newcastle Street  
Leederville, WA, 6007

I declare that the information given to me is correct to the best of my knowledge and that I am entitled to apply for access to the health records referred to above under the terms of the *Privacy Act*.

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

Authorised Practice signature \_\_\_\_\_ Date \_\_\_\_\_