



Authorisation For Release Medical Information/Records

Name of Previous Doctor/Surgery: _____

Address: _____

Phone: _____ Fax: _____

The following patient(s) are now attending this Practice. In order to facilitate ongoing care, we would be grateful if you could please forward copies of any relevant medical history, correspondence and investigations.

| Patient Name | DOB | Address |
|--------------|-----|---------|
| | | |
| | | |
| | | |
| | | |

Please advise of last claim dates and send documents for below item numbers

| Date | Date | Specific Information Required |
|-------------|----------------|-------------------------------|
| 721/723 | 732 | |
| 703/705/707 | 715 | |
| 900/903 | 2700/2715/2712 | |

Please advise regular providers that you refer your patients

| Pathology Provider | Radiology Provider | Any Additional Information Required to continue |
|--------------------|--------------------|---|
| | | |

I hereby request and authorise the release/ transfer of my medical history to Sippy Downs Family Clinic.

Patient Signature: _____ Date: _____

Doctor Requesting: _____

Please fax medical records to 07-5391 3299 or send via Medical Objects.

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