SIPPYDOWNS FAMILYCLINIC
Where your health comes first!

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Phone (07) 5391 3444 | Fax (07) 5391 3299
Shop 1, 8 Fairfax St, Sippy Downs QLD 4556

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.