

## Request for Release of Personal Health Information

Patient details					
Title	☐ Mr ☐ Mrs ☐ Ms ☐ Me	ast 🗌	Miss		r Prof Other
Family name					
Given name/s					
Date of birth	/ /				
Address					
Details of previous clinic t	o transfer records from				
Clinic name					
Clinic address					
Clinic phone		Clinic fax			
DVDs or USB sticks) I request that a copy of my m	• Medical clinic & doctor (Please redical history or summary be forw			cal does i	not accept information on CDs,
Doctor name					
Clinic name					
Clinic address					
Clinic phone			Clinic fax		
Please tick if completed and record the date of the last assessment or review for this patient	Assessment or review:  GPMP or mental health TCA Diabetes plan Asthma plan Medication review Other health check CMA		/ / / / / / / / /	/ / / / / /	eted:
	Name	D.O.B	/	/	Signature
Family members to include in transfer	Name	D.O.B	/	/	Signature
	Name	D.O.B	/	/	Signature
(Signature only required if family member is 16 years or older)	Name	D.O.B	/	/	Signature
	Name	D.O.B	/	/	Signature
	Name	D.O.B	/	/	Signature

I understand that a fee may be charged for the cost of providing access or copies. The record can be faxed or sent via registered post to the receiving clinic detailed above. I hereby authorise release of my medical history

\_\_ Date: / /

to Better Medical.

Signature of person requesting:\_\_

M1006