Authorisation to Release Medical Records

Dear Doctor: ____

Previous Clinic Name: ____

Address: ____

City/Town: ____ Post Code: __________________

I hereby consent to the release of my/our medical information to:

Dr Wajib Dib at Together Medical Family Practice

Level 1, 1571 Ferntree Gully Road, Knoxfield 3180. Date: ________________________

Patient Name: ____ DOB: ________________________

Signature: ____

Patient Name: ____ DOB: ________________________

Signature: ____

Patient Name: ____ DOB: ________________________

Signature: ____

The above-named patient(s) is now attending this practice and has asked us to arrange for the transfer of the following information:

Medical Summary and history, correspondence and investigation results and history of EPC items.

For medicolegal reasons do not send original records.

Our HealthLink EDI is: togmedfp (Dr Wajib Dib, PN 2960899W)

Signed (Witness) __________________________________ Print Name: ________________________

Thank you.

Together Medical Family Practice
Level 1, 1571 Ferntree Gully Road, Knoxfield 3180
Ph: 03 8566 8540 Fax: 03 8678 3225 email: reception@togethermedical.com.au