PATIENT RELEASE OF NOTES

Dr Fiona Conlon	4659874Y	Dr Jenny Asquith	063686JA
Dr Mythily Reddy	4291429F	Dr Simone Foley	2448335F
Dr Emma Schimann	4605157X	Dr Toby Jackson	452941DY
Dr Kelly McLean	4651651A	Dr Jessie Broadbridge	434723BJ
Dr Bethany Sullivan	4476637L		

To:

Address:

Phone:

Fax: Date Sent:

Dear Doctor,

The patient(s) listed below now attend Shell Cove Family Health as their regular practice.

We would be grateful if you could forward:

☐ An accurate Health Summary via fax

☐ Full Medical History on CD or USB in XML format

☐ Other ____

We understand that a fee may apply and request that you advise the patients of any fees involved in the transfer of their records

I hereby request and authorise the release of my medical records:

Patient Name: ____ D.O.B: ______________________

Signature: ____ Date: _______________________

Other Family Members:

*Please note that all patients over **14 years** of age MUST sign to authorise transfer of their medical records*

Patient Name: ______________________ D.O.B: _________ Signature: ____________________

Patient Name: ______________________ D.O.B: _________ Signature: ____________________

Patient Name: ______________________ D.O.B: _________ Signature: ____________________

Thank you - *Shell Cove Family Health*

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