Shell Cove
FAMILY HEALTH

PATIENT RELEASE OF NOTES

Dr Fiona Conlon	4659874Y	Dr Simone Foley	2448335F
Dr Daisuke Ikeda	2997128K	Dr Mythily Reddy	4291429F
Dr Mina Nafari	4663578W	Dr Jessie Broadbridge	434723BJ
Dr Mark Burgess	449404HJ	Dr Kelly Mitchell	4768908J
Dr Alison Remynse	5621856X	Dr Hani Sakr	5488238A

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 authorize 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 authorize 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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