BIBRA LAKE MEDICAL CENTRE

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HEALTH Provider No. 2568548F

AUTHORITY TO RELEASE MEDICAL INFORMATION

Date: ______________________

____ Tel: ______________________

____ Fax: ______________________

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Dear Doctor

We wish to advise that the patient(s) listed below are now attending this practice and have requested their medical file to be transferred here. Could you please transfer the file (via XML, registered mail or fax).

____ DOB: _____________________

____ DOB: _____________________

____ DOB: _____________________

____ DOB: _____________________

Please include the following information:

EPC Item	Completed	Date Billed
GPMP (Item 721)	Y/N	
TCA (Item 723)	Y/N	
Health Assessment (Items 705, 707, 732)	Y/N	
Mental Health Plan	Y/N	
Recalls	Y/N	
Other relevant information	Y/N	

I give permission for any relevant records to be forwarded to Bibra Lake Medical Centre.

Name: ___________________________________ Signature: _____________________________

Address: ____ Tel: ____________________

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