



Release of Patient Medical Information Form

Date: / /

Dear Doctor: _____

Of (practice name): _____

Phone Number: _____ Fax Number: _____

The following patient/s are now attending my GP Tamworth. My GP Tamworth would be grateful if you could please send a disc or USB in XML format only or a patient health summary and if possible include any relevant reminders that will assist us in continuing the exceptional medical treatment you have initiated.

Details of patient:

Surname/family name: _____

Given names: _____

Date of birth: _____

Address: _____

Family members wishing to be transferred under age of 16 to be listed below:

Full Name: DOB:

Full Name: DOB:

Full Name: DOB:

Full Name: DOB:

I _____ give permission for my previous medical history to be forwarded to My GP Tamworth.

Signature: _____

Date: _____

*My GP Tamworth
Shop 32-34, 432-452 Peel Street Tamworth NSW 2340
Po Box 386, Tamworth NSW 2340
Phone: 02 5701 5533 Fax: 02 5701 5534
Email: reception@mygptamworth.com*

PLEASE NOTE THAT MY GP TAMWORTH USES BEST PRACTICE SOFTWARE AND ELECTRONIC COPES ARE PREFERRED
If there is a fee for the transfer of their records please notify the patient directly. Important notice regarding confidentiality: The contents of this facsimile transmission are intended solely for the attention of the names addressed. The contents are confidential and may be protected by legal professional privilege and/or doctor/patient confidentiality. If you are not the intended recipient of this facsimile, you are hereby informed that any use, copying, distribution or publication of the facsimile or any information contained therein is prohibited. If this facsimile has been received by you in error, kindly advise us immediately by telephone.