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.