



85-91 Commercial Road (PO Box 239), Yarram Vic 3971
Phone: 03 5182 0222 Fax: 03 5182 0395 Email: medical.centre@ydhs.com.au

**** AUTHORISATION TO RELEASE MEDICAL RECORDS****

Date:

Dear Dr:

.....

Fax:.....

RE: Name

D.O.B:

Medicare Number:

The above named patient is currently attending this practice and has asked us to arrange for the transfer of the following information, Medical Summary and History, Correspondence and investigations for the last 12 months, History of EPC items

Item	Date Created or Reviewed
GPMP,	
Review Items	
Health Assessments	
Mental Health Plans	

FOR MEDICO LEGAL REASONS, DO NOT SEND ORIGINAL RECORDS.

I hereby give my permission for all relevant medical records held by your organisation to be forwarded to the Yarram Medical Centre.

****PATIENT AUTHORISATION****

I understand that there may be a charge for this service and I/We agree to pay a reasonable fee.

Signed: _____

Witness name of staff member _____