MOOLOOLABA SURGERY

BULK BILLING AVAILABLE

Authorisation For Release Medical Information/Records

Name of Previous Doctor/Surgery:_____

Address:_____

_____

Phone:_____ **Fax:**_____

The following patient(s) are now attending this Practice. In order to facilitate ongoing care, we would be grateful if you could please forward copies of any relevant medical history, correspondence and investigations.

Patient Name	DOB	Address

Please advise of last claim dates and send documents for below item numbers

	Date		Date		Specific Information Required
721/723		**732**			
703/705/707		**715**			
900/903		**2700/2715/2712**			

Please advise regular providers that you refer your patients

Pathology Provider	Radiology Provider	Any Additional Information Required to continue

I hereby request and authorise the release/ transfer of my medical history to Sippy Downs Family Clinic.

Patient Signature: _____Date: _____

Doctor Requesting: _____

Please fax medical records to 07- 07 5646 5998 or send via Medical Objects.

Shop 2, 23 Brisbane Rd, Mooloolaba QLD 4557
Trading Hours: Monday to Friday: 8:00am - 6:00pm
PH: 07 5665 9899 FAX: 07 5646 5998
www.mooloolabasurgery.com.au