NORTHSIDE FAMILY DOCTORS

Medical Information Request

Patient authorisation to release records to Northside Family Doctors

01 Patient details

Full name

Date of birth

Previous name (if applicable)

Phone

Current address

Previous address at former practice (optional)

Medicare number (optional)

IRN (beside name)

Former patient no. (optional)

02 Request to the healthcare provider holding the records

Practice / provider name

Secure messaging address / fax / postal address

03 Information requested

Please tick the relevant items and specify the period or episode of care.

- ☐ Health summary
- ☐ Medication list and allergies
- ☐ Relevant consultation notes
- ☐ Pathology and imaging reports
- ☐ Specialist / hospital correspondence
- ☐ Complete medical record

Date range, condition / episode, other information or exclusions

04 Patient authorisation

I authorise the provider named above to release the information selected to Northside Family Doctors for my ongoing care. I understand this may include sensitive health information within the scope I have selected. I have had the opportunity to ask questions and may limit this request. I can withdraw this authorisation by contacting the provider before the information is released; this cannot undo a release already made.

Patient / authorised representative signature

Date

Representative name, relationship and authority (if applicable)

RECEIVING PRACTICE - complete before sending

Requesting clinician: _____ Secure destination: _____