BENALLA CHURCH STREET SURGERY PTY LTD

MEDICAL RELEASE FORM

Date_____

Dear Dr._____

Address _____

_____

_____

Phone: _____ Fax:_____

RE: _____ DOB: _____

_____ _____

_____ _____

The above patient/s have elected to attend this surgery for ongoing medical care. Would you please forward any information of their past medical history? Please note signed authority from patient below. **We prefer to receive electronic histories via <u>Medical Objects</u> or if sending by CD please use <u>HTML</u> only file. Thank you.**

Please advise the following:

Item	Date Last Billed
GPMP (item 721)	
GPMP TCA (item 723)	
GPMP Review (item 732)	
Health Assessment	
Mental Health Plan (item 2710)	
Mental Health Review (item 2712)	

Yours Sincerely

…….

Dr _____

<u>AUTHORITY TO RELEASE MEDICAL INFORMATION</u>

I/we hereby authorise the release of any medical information to be forwarded to the above medical practice.

Signature_____

_____