Better Medical

Request for Release of Personal Health Information

Patient details

Title	☐ Mr ☐ Mrs ☐ Ms ☐ Mast ☐ Miss ☐ Dr ☐ Prof ☐ Other
Family name	
Given name/s	
Date of birth	/ /
Address	

Details of previous clinic to transfer records from

Clinic name		
Clinic address		
Clinic phone		Clinic fax

Details of receiving Better Medical clinic & doctor *(Please note: Better Medical does not accept information on CDs)*

I request that a copy of my medical history or summary be forwarded to:

Doctor name		
Clinic name		
Clinic address		
Clinic phone		Clinic fax
Please tick if completed and record the date of the last assessment or review for this patient	Assessment or review: ☐ GPMP or mental health ☐ TCA ☐ Diabetes plan ☐ Asthma plan ☐ Medication review ☐ Other health check ☐ CMA	Date completed: / /20 / /20 / /20 / /20 / /20 / /20 / /20

Family members to include in transfer *(Signature only required if family member is 16 years or older)*				
	Name	D.O.B	/ /	Signature
	Name	D.O.B	/ /	Signature
	Name	D.O.B	/ /	Signature
	Name	D.O.B	/ /	Signature
	Name	D.O.B	/ /	Signature
	Name	D.O.B	/ /	Signature

I understand that a fee may be charged for the cost of providing access or copies. The record can be faxed or sent via registered post to the receiving clinic detailed above. **I hereby authorise release of my medical history to Better Medical.**

Signature of person requesting:_____ Date: __/____/_____