



Request for Release of Personal Health Information

Patient details

Title	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Mast <input type="checkbox"/> Miss <input type="checkbox"/> Dr <input type="checkbox"/> Prof <input type="checkbox"/> 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:	Date completed:	
	<input type="checkbox"/> GPMP or mental health	/	/20
	<input type="checkbox"/> TCA	/	/20
	<input type="checkbox"/> Diabetes plan	/	/20
	<input type="checkbox"/> Asthma plan	/	/20
	<input type="checkbox"/> Medication review	/	/20
	<input type="checkbox"/> Other health check	/	/20
Family members to include in transfer <small>(Signature only required if family member is 16 years or older)</small>	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: ___/___/_____