The Sleep Cottage
2/83 Kareena Road, Miranda NSW 2228
Ph: (02) 9195 6677 Fax: (02) 9198 9511
frontdesk@thesleepcottage.com.au

Consent to Release Medical Information

Patient Full Name: _____

Date of Birth: _____/_____/_____

Address: _____

Phone: _____

Email: _____

This letter is to advise that (Patient Full Name)_____ or their Parent/Carer, has granted permission for Dr _____ (the current treating medical physician) to release medical information to the below physician/practice.

**Required Fields*
***Dr Full Name**: _____

Practice Name: _____

***Address**: _____

***Phone**: _____

***Fax**: _____

Email: _____

Patient or Parent/Carer Signature:_____

Parent or Parent/Carer Full Name: _____

Date: _____

Please contact us with any queries.

Yours sincerely,
The Sleep Cottage