Douglas Family Medical Centre

228 Riverside Blv
Douglas, QLD, 4814
Ph: (07) 4779 2480
Fax: (07) 4725 0188

AUTHORITY TO RELEASE MEDICAL INFORMATION

TO:

Doctor: **Medical Practice:**

Phone: **Fax:**

PATIENTS:

1. Name:_____ DOB: _____/_____/_____
2. Name:_____ DOB: _____/_____/_____
3. Name:_____ DOB: _____/_____/_____
4. Name:_____ DOB: _____/_____/_____
5. Name:_____ DOB: _____/_____/_____

REQUESTING:

☐ Health Summary

☐ Records of care from _____ to _____ only.

☐ Records of care concerning the following condition(s)_____

☐ Other: Specify: _____

☐ Confer with other person orally about information in my medical record.

I do hereby authorise and direct you to release my medical records to Douglas Family Medical Centre, 228 Riverside Blv, Douglas, QLD, 4814, as I am now attending this medical practice.

Name (printed)_____ Patient Signature:_____ Date: _____/_____/____

Name (printed)_____ Patient Signature:_____ Date: _____/_____/____

If you are 16 or over you need to sign yourself!

Doctor's name:_____ Doctor' Signature:_____ Date: _____/_____/____