

# Gilles Plains Medical Centre



Gilles Plains Medical Centre

Shop 33 & Shop 35,

North East Road,

Gilles Plains SA 5086

Ph: 08 8166 1806

Fax : 08 8126 4145

Email : Reception@gillesplainsmedicalcentre.com.au

Dear Dr. \_\_\_\_\_

The patient whose name appears below, has recently attended Gilles Plains Medical Centre and has requested that his/her medical records be forwarded to our practice.

Please find below an 'Authority to release Records' consent, signed by the patient.

Information requested:

- |  |   |
|--|---|
| <input type="checkbox"/> 1-page summary    | <input type="checkbox"/> Full Patient History |
| <input type="checkbox"/> Discharge summary | <input type="checkbox"/> Operative Report     |
| <input type="checkbox"/> Radiology report  | <input type="checkbox"/> Care Plans           |
| <input type="checkbox"/> Others            |   |

Format requested:

- |                                     |                              |
|-------------------------------------|------------------------------|
| <input type="checkbox"/> Paper form | <input type="checkbox"/> USB |
| <input type="checkbox"/> Email      |                              |

Thank you for your help.

Yours sincerely,

Gilles Plains Medical Centre

Patient's Full Name: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_

I, \_\_\_\_\_ give consent for my records to be sent to  
Gilles Plains Medical Centre.

Thank you.

Signature of Patient: \_\_\_\_\_

Date: \_\_\_\_\_

**Dr Ting Yeung Kwok**

**Provider number : 5410475Y**