



DR KATE CLOWES
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Your Doctors

noreply@yourdoctors.com.au

Dear Your Doctors,

I am/we are patients of Dr Kate Clowes and authorise you to send her a copy of my/our medical record at her new address.

Many thanks and kind regards,

Signed:

Full Name:

Date of Birth:

Address:

Date:

*Please note that all patients/family members 16 years and over are requested to sign this authorisation