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**Medical Records Request Form**

**Ninox Chancellor Park**

17-19 Chancellor Marketplace

18 University Way QLD 4556

P: (07) 5453 4404

F: (07) 5379 5288

E: chancelloradmin@ninoxhealth.com

Dear

As the patient listed below now attends this practice, please forward a copy of their medical records and any other clinical information to assist in the continued management of the healthcare.

☐ Health Summary

☐ Full medical history

☐ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient consent**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

consent to the release of my medical records and any other relevant clinical information to Ninox Health on Buderim.

Patients name: (Please print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

If not patient signing - name: (please print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your relationship to patient: (e.g. Mother, Father, guardian, carer) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Objects preferred (We accept USB - Please note discs not accepted as are non-compatible):**

☐ DR Kerry Whannel

☐ DR Lucy Randall

☐ DR Jamal Hussain