Health & Wellbeing Wulguru

4/340 Stuart Dr
Wulguru, QLD 4811
Ph: (07) 4778 3355
Fax: (07) 4778 3420

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 Health and Wellbeing Wulguru, Shop 4/340 Stuart Drive, Wulguru, QLD 4811, 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!