GREENROAD
MEDICAL CENTRE

PATIENT REQUEST FOR RELEASE OF MEDICAL RECORDS

Date: ..... / ..... / .....

I/We: .....

Of (address).....

Authorise: *(Doctor from previous location)*

Doctor: .....

Address: .....

To release my / my dependents Medical Records to Green Road Medical Centre.

PLEASE NOTE: Medical records for spouse or partner can only be transferred by signing their own authority form.

Patient Name	DOB	Patient Name	DOB

Signature (Patient/ Guardian):

The above patient/s is/are attending this practice.

We would appreciate a complete medical history along with the following information:

GPMP	Date:_____	Diabetes Annual Cycle of Care	Date:_____
TCA	Date:_____	Asthma Review	Date:_____
>75 HHA	Date:_____	Medications Review	Date:_____
GP Mental Health Plan	Date:_____	45 - 49yr Health Check	Date:_____

Thank you for your assistance.

PLEASE NOTE:

If sending medical records via email or other digital means, please save as '.xml' format.

Email: smc.reception@seacrestmc.com.au
Post: Green Road Medical Centre, 29 Green Road, Hillary's WA 6025
Fax: (08) 9448 6640 Phone: (08) 9448 4433