AUTHORITY TO RELEASE MEDICAL RECORDS

OAKHILL CLINIC PTY LTD

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Dear _____

Patients Name: _____D.O.B:_____

Please include the following family members
(Patients 16 years and older need to sign their own consent forms)

Patients Name: _____ D.O.B:_____

Patients Name: _____ D.O.B:_____

Patients Name: _____D.O.B:_____

The above patient, whose signature appears below, has requested that our practice continue their management and the management of any family members that may also be listed. In order to ensure continuity of care, we would appreciate if their medical records be forwarded to our practice at your earliest convenience.

Information Required

Hospital UR Number _____

- ☐ Medical History last 2 years
- ☐ Investigation Results
- ☐ Other
- ☐ Discharge Summary
- ☐ Operation Report
- ☐ URGENT

_____

I hereby authorize you to forward the above information to Dr _____ to assist in the continuing care of me or my family.

SIGNED: _____DATE: _____

Please note that we use Medical Director 3.18.c CD in XML. format or a transfer via MD Exchange would be appreciated. ONLY IF YOU HAVE MEDICAL DIRECTOR .XML FILES will work, if using other medical programs please send paper file. Alternatively you could send file via Argus on 539317@argus.net.au