Bournemouth Medical Centre

16 Bournemouth Cres, WEMBLEY DOWNS, WA, 6019
Phone: (08) 9341 3399 Fax: (08) 9341 1696

Written Authority

to obtain information from another medical practice

To: DR _____

Of_____

_____

The undersigned are now attending this practice. To allow for continuing medical care of this/these patient/s, would you please provide our practice with a copy or a summary of their medical history? The patient/s permission to release this confidential information is provided below.

Please also complete the following if applicable:

GPMP 721	Date _____
TCA 723	Date _____
>75 Health Assessment	Date _____
GP Mental Health Plan 2710	Date _____
Asthma Care Plan 2546	Date _____
Diabetes Annual Assessment 2517	Date _____

Please forward this at your earliest convenience to ensure continuity for this/these patient/s.

Date _____ Patient's Signature _____

Patient's Full Name _____ Date of Birth _____

Patient's Address _____

_____

Other Family Member's Names, signatures & D.O.B

_____

_____

_____

You may download this form and fax/email to us