

WEMBLEY DOWNS FAMILY PRACTICE

(Bournemouth Medical Centre)

16 Bournemouth Crescent, Wembley Downs, WA 6019

Phone: (08) 9341 3399 Fax: (08) 9341 1696

Written Authority

to obtain information from another practice

To: DR.....

of.....

The undersigned is/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 of their medical record at the earliest?

The patient/s permission to release this confidential information is provided below.

NOTE: Kindly send as *xml* format in a CD.

WE DO NOT ACCEPT LARGE VOLUME PHOTOCOPIED PATIENT NOTES

Patient's Signature Date:.....

Patient's full name..... DOB:.....

Patient's Address:

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Other family members' Names, DOB & Signatures:

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