58 Pinewood Drive, Mount Waverley VIC 3149
401 Blackburn Road, Mount Waverley VIC 3149
Ph: (03) 9802 8000 | Fax: (03) 9802 3456 | Email: wfhc@wfhc.com.au

AUTHORITY TO RELEASE PERSONAL HEALTH INFORMATION

(please print clearly)

Patient Name: _____

DOB: _____ **Medicare No:** _____

Address: _____

Other family members' names	DOB	Signature if member over 18

XML format preferred (Note: If your clinical software does not export XML files, alternatively please send HTML/PDF files, complete paper copy)

Please TICK:

☐ Transfer of records **TO** / **FROM** (please circle one):

Medical clinic name: _____

Address: _____

Ph: _____ Fax: _____

☐ Release records for insurance claims

☐ Release for Employment medical

☐ Other, please specify _____

☐ Release to all Healthcare providers (due to ongoing medical issues)

Records may include – past medical history, immunisations, investigation results, current medication, advice on GPMP, Team care arrangements and dates unless stated otherwise.
Notes:

_____

_____

I hereby authorise the clinic to release my medical records and acknowledge this may be revoked at any time by myself in writing to the clinic.

Patient/Authorised Person Name: _____

Patient/Authorised Person Signature: _____

Date: _____