REQUEST FOR RELEASE OF PERSONAL HEALTH INFORMATION

Better Medical

□ Bridgewater	□ Hahndorf	□ Mt Barker	□ M Barker Sth	□ Stirling	□ Strathalbyn
Tel: 8339 2077 Fax: 8339 6483	Tel: 8388 7066 Fax: 8388 7415	Tel: 8391 1300 Fax: 8398 3913	Tel: 8391 2055 Fax: 8391 5342	Tel: 8339 4344 Fax: 8339 2979	Tel: 8536 4466 Fax: 8536 4488

Patient Details

Patient Name:
Date of Birth:
Address:

Details of Previous Clinic to Transfer Records From

Clinic Name:
Clinic Address:
Phone:

Details of Receiving Better Medical Doctor & Clinic

I REQUEST THAT A COPY OF MEDICAL HISTORY OR A SUMMARY BE FORWARDED TO:

Doctor Name:
Clinic Name:
Clinic Address:
Phone:

Please record the dates of the last assessment or review completed for this patient

Tick if completed	Assessment/Review	Date
	GPMP or Mental Health	
	TCA	
	Diabetes/Asthma SIP	
	Medication Review	
	Other Health Check	
	CMA	

Family Members to Include in Transfer

Name:	**DOB:**	**Signature:**
Name:	**DOB:**	**Signature:**
Name:	**DOB:**	**Signature:**
Name:	**DOB:**	**Signature:**

(Signature only required if family member is 16 years or older)

I understand that a fee may be charged for the cost of providing access or copies. The record can be faxed or sent via Registered post to the receiving clinic detailed above.

I hereby authorise release of my medical history to Better Medical.

Signature of Person requesting_____ Date / /