

**Authority Request to release a Patients' Medical records to Black Fish Medical Clinic**

Date: \_\_\_\_\_

I, \_\_\_\_\_ (Please PRINT your full name)

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

Post Code: \_\_\_\_\_

Give my previous Doctor: \_\_\_\_\_

Of (Practice/Clinic name): \_\_\_\_\_

Practice Clinic address: \_\_\_\_\_

Post Code: \_\_\_\_\_

Phone No: \_\_\_\_\_ Fax: \_\_\_\_\_

**Give permission to release my medical records/information to Black Fish Medical Clinic. (We use Medical Director if you do not use MD please provide paper copy of full patient record).**

 Patients' signature: \_\_\_\_\_

Please advise when/if you have billed for the following:

GPMP	Item 721	Date: _____
TCA	Item 723	Date: _____
GPMP Review	Item 732	Date: _____
TCA Review	Item 732	Date: _____
GPMHC	Items 2712, 2715, 2717	Date: _____
HMR	Item 900	Date: _____
Over 75 years old Health Assessment		Date: _____

**Request from Dr. Ferghal Armstrong / Dr Patrick Steele /Dr Saveena Nithiananthan**

*This facsimile may be confidential. If you are not the intended recipient, you must not disclose, use or copy the information contained in it. No confidentiality is waived, lost or destroyed by reason that this facsimile has been mistakenly transmitted. If you have received this facsimile in error, please telephone Black Fish Medical Clinic immediately on 03 59971819.*