Black Fish
MEDICAL CLINIC

215-235 Rossiter Road, Koo Wee Rup VIC 3981
T 5997 1819 F 5997 1980 E reception@blackfishmedicalclinic.com.au

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