LAKESIDE SQUARE MEDICAL CENTRE

Shop 2, 9 Village Way, Pakenham VIC 3810
ph 0397962111 fax 0397962137

AUTHORITY FOR TRANSFER OF MEDICAL FILES

To: ________________________________

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Dear Doctor,
Please send all relevant medical information for the patient/s listed below, in the form of either:

· a summary of the relevant past history and current treatment;
· a copy of the medical files;

to the above address.
Thanking you,
Signed ____ Date: ____/____/____

I hereby authorise the release of the above medical information for:
Name: Date of Birth:
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1) ____ ____________________
2) ____ ____________________
3) ____ ____________________
4) ____ ____________________
5) ____ ____________________
6) ____ ____________________

Yours sincerely,
Signature: ________________________________ Date: ____/____/____
Name: ____
Address: ____
Previous Address (if applicable):
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