Forrest Road
MEDICAL CENTRE

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Dr Shahab Taj	MBBS ACRRM, AST(Gen Med)
Dr Fatima Stanakzai	MD, FRACGP
Dr Nicole Afonso-Conradie	MBBCH FRACGP

PATIENT REQUEST FOR RELEASE OF MEDICAL RECORDS

DATE: _____

I/WE _____

Of _____

Authorise (previous medical centre)

PRACTICE NAME: _____

ADDRESS: _____

_____

To release my/my dependents Medical Records to Forrest Road Medical Centre.

NAME:_____ D.O.B: _____

NAME:_____ D.O.B: _____

NAME: _____ D.O.B: _____

The above patient/s is currently attending this surgery. I would appreciate if you could forward any medical records, reports and correspondence pertaining to their medical history in order to assist in the future management of this patient/s

Please include any GPMP/TCA, MHCP, HEALTH ASSESSMENTS.

SIGNATURE PATIENT/GUARDIAN: _____

Thank you for your assistance

We use Best Practice, notes are accepted by email in XML format to:
reception@forrestroadmedical.com.au