

Suites 1-4, 1 Gum Tree Drive

Goonellabah NSW 2480

Phone: 02 6619 2999 Fax: 02 9171 2204

AUTHORISATION TO OBTAIN MEDICAL RECORDS

I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

of\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

give permission to:

**□ Dr Mercia Van Jaarsveld** **□ Dr David Gunn**

of Gum Tree Family Medical to obtain a full summary of my medical records pertaining to myself from Dr\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In this request please supply the date of last:

Health Assessment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diabetes Care Plan \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GP Management Plan \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Asthma Care Plan \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Team Care Arrangement\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 45 Year Old Health Check \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mental Health Care Plan\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pap Smear Screen \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This is my request and I authorise Doctor to carry this out on my behalf.

Other family members include:

Name DOB

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signed…………………………….……………… Dated ………………………………………

**If you use Best Practice:**

**Please send us an Electronic copy of the Medical Records in XML FORMAT.**

**For all other Medical Software – NO ELECTRONIC COPIES PLEASE.**