185 Molesworth Street
LISMORE NSW 2480

Telephone: (02) 6621 2502
Facsimile: (02) 6621 2269
Email: info@lismoreclinic.com.au

AUTHORISATION TO OBTAIN MEDICAL RECORDS

The patient(s) listed below are now attending this Practice for ongoing medical care. Please find below patient(s) authority to forward medical records to us.

I, ____ Date of Birth: ____________________________________

Address: ____

give permission to Dr ________________________________of The Lismore Clinic to obtain a full summary of

my medical records pertaining to myself from Dr____

located at ____.

In this request please supply dates for :

Health Assessment	Date:	Diabetes Mellitus	Date:
GP Management plan	Date:	Asthma Cycle of Care	Date:
Team Care Arrangements	Date:	45 Year Old Health Check	Date:
Mental Health Care Plan	Date:	Taking of Cervical Screen>4years	Date:

Other: ____

Other family members included in this request are as follows:

Full Name:	Date of Birth:	Signature if over 16 years of age:

If you use Medical Director:

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

For all other Medical Software – NO ELECTRONIC COPIES PLEASE.

Signed: ……………………………………………………………………… Date: ……………………………………………………………………….