AUTHORISATION FOR DISCLOSURE OF MEDICAL INFORMATION

Kincraig Medical Clinic

6 Cedar Avenue, Naracoorte SA 5271

P: 87627700 F: 87621169

E: kincraigmc@kmc.com.au

Patients Full Name: _____DOB: _____

Previous Practice/Doctor: _____

Other family members (under age 18):

_____ D.O.B: _____

_____ D.O.B: _____

_____ D.O.B: _____

_____ D.O.B: _____

Could you please assist us by advising if the patient(s) have had any of the following assessments or reviews conducted in the last 2 years:

GPMP	Date: _____
GPMP Review	Date: _____
Home Medication Review	Date: _____
Health Assessment	Date: _____
GP Mental Health Plan	Date: _____

*The above patient is now attending the **KINCRAIG MEDICAL CLINIC** and has requested that copies of relevant information from his/her medical history be forward to us. This will greatly assist us with further management.*

Yours faithfully,

Dr _____ Signature:_____

I, the above name, authorise the release of Medical Information from my files at your surgery to be sent to the below address.

Patients' signature: _____ Date:_____