HALY HEALTH AND SKIN MEDICAL CENTRE

240 Haly Street, Kingaroy QLD 4610
PO Box 776, Kingaroy QLD 4610
Telephone: 07 41627787 Fax: 07 41627786
Email: reception@halyhealth.com.au
ABN: 81 150 067 619

Date: _____/_____/_____

Dear Doctor: _____

Medical Centre: _____

Address: _____

_____

Re: ……. DOB: ……..

Re: ……. DOB: ……..

Re: ……. DOB: ……

Re: ……. DOB: ……

AUTHORITY FOR RELEASE OF MEDICAL RECORDS

I,_____, give permission for my medical records to be forwarded to Haly Health & Skin Medical Centre to assist in my continued medical care.

Patients Signature: _____

(Please note – All patients over 18 years of age must sign their own consent for transferring records)

The above mentioned patient/s now attends this surgery. Would you kindly forward any relevant medical information, specialist letters, reports or pathology regarding this/these patient/s as it would be helpful for their continued medical care.

Preferred method via Medical Objects would be appreciated.

Please also advice of the dates the following items were last billed:

721:	Health Assessment:
723:	Mental Health Care Plan:
732:	Mental Health Care Plan Review:
	Diabetes Cycle of Care:

Yours sincerely
Haly Health & Skin Medical Centre