

16 Main Road,

Belair SA 5052

Telephone: 8278 8311

Fax: 8278 8223

Date:

Dear Dr.

Name and Address of previous practice:

The patient’s whose name appears below, has recently attended Belair Medical and has requested that his/her medical records be forwarded to our practice.

Please find below an ‘Authority to release Records’ consent, signed by the patient.

**We are particularly interested in the dates of previous Care Plans, Mental Health Plans and any relevant correspondence from the previous 3 years.**

Thank you for your co-operation.

Yours sincerely,

Belair Medical

Patient’s Full Name:

Patient’s Date of Birth:

I, give consent for my records to be sent to Belair Medical.

Thank you for your past care.

Signature of Patient:

Notes: