fountain gate medical centre

151 KURRAJONG RD
NARRE WARREN VIC 3805
PHONE: (03) 9704 8011
FAX: (03) 9704 1841
www.scmg.com.au

Date ……

Dear Dr……
Clinic name and address……
……..

Patient Name:…… ……..
Date of Birth: ……
Address: ……

This patient is now attending this clinic and has requested that a copy of their medical records be transferred to our clinic. Please send either copies or a summary of their history. If sending by electronic format, please ensure that it is pdf,html, tif and doc files. We do not accept XML files. PLEASE DO NOT SEND THEIR ORIGINAL FILES.

In particular I would appreciate these particular files be sent:
……
Please also provide dates for the following (if applicable):
GPMP, TCA, Health Assessment, Diabetes Care, Asthma Care & Mental health Treatment Plans.

Thank you for your help.

Authorisation

I, …… *(patient)* authorise the release of my medical records. Please send them to Dr…… at the above address.

Signed…….. Date ……

Dr Jacob Dessauer
Dr Michael Long
Dr Melissa Wong
Dr Karen Head