SIRONA
WOMEN'S HEALTH

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reception@sironawh.com.au

REQUEST FOR RELEASE OF HEALTH INFORMATION

PATIENT DETAILS (your details)

Title:_____ **First name:**_____
Surname: _____ ☐ **Other names:**_____
DOB: ☐☐/☐☐/☐☐☐☐ **Mobile:** ☐☐☐☐-☐☐☐-☐☐☐

TRANSFERING FROM (who we are obtaining your records from)

Clinic name:_____
Address: _____
City/Town: _____**Post code:** ☐☐☐☐ **State:** _____
Phone: ☐☐-☐☐☐☐-☐☐☐☐ **Fax:** ☐☐-☐☐☐☐-☐☐☐☐
Email:_____

PRACTICE DETAILS

The above mentioned patient is now attending Sirona Women's Health, would you kindly forward their records including the following:

- ☐ Accurate Health Summary with relevant correspondence and results
- ☐ Care Plan/Mental Health Care plan/Eating disorder plan/Health Assessment claimed within the last two (2) years
- ☐ Entire Medical File
- ☐ Other _____

This will assist in the future management of this patient. Records can be sent to Sirona Women's Health by fax, mail or medical objects.

If there are funds to be finalised before the exchange of this file, please kindly contact the patient on the number listed above.

PATIENT'S SIGNED AUTHORITY

By signing this form, I am authorising the release of my confidential medical history to SIRONA WOMEN'S HEALTH.

Patient's name:_____

Patient's signature: _____**Date:** _____

Sincerely,
Doctor's name: _____**Provider number:** _____

Doctor's signature:_____