CONSENT RELEASE FORM to TOTAL HEALTH CARE

To Whom It May Concern,

I, ____,

DOB: ______/_______/_____________

Medicare card number:
____
Reference on card: ___________ Expiry date: ______________________

request that a copy of my medical record/s are to be transferred to
____ (Total Health Care practitioner name)

I give informed consent for you to provide a copy of my medical records that you hold on me together with a clinical summary to:

Total Health Care
Suite 304, Level 3,
35 Spring Street
Bondi Junction NSW 2022

OR by Email: reception@totalhealthcare.net.au OR by Fax: (02) 9386 1336

Yours faithfully,
____

Dated _______/_______/________________
(patient signature if 18 years or older/guardian signature)

____
(print name of person signing above)