**Medical History and Medical Information Release Request**

**To:** Doctor/Clinic ………………………………………………………………………………

 Address ……………………………………………………………………………….

 ………………………………………………………………………………

 ……………………………………………………………………………….

**Re:** Patient’s Name ……………………………………………………DOB: ………………

 *Additional family members requesting release of medical history*:

 Patient’s Name: ………………………………………………………....DOB: ………………

 Patient’s Name: …………………………………………………………DOB: ……………….

 Patient’s Name: …………………………………………………………DOB: ………………

*The patient(s) listed above have elected to attend Glenmount Medical Clinic for future medical care. As you have been the previous treating doctor, we would appreciate copies of relevant medical history details. In addition to the patient’s medical history, we would also appreciate if the following information was included (where relevant):*

- Date of last Health Assessment

- Date of last GP Management Plan/Reviews (721 and 723)

- Date of last Team care Arrangement /Reviews (732 and 732)

- Date of last Home Medication Review

Thank you for your assistance

**Patient Authority**

I hereby give authority for my medical history and information to be transferred

Patient’s Name: ……………………………………………… Date: ……………..

Signed: …………………………………………………………………………………

Glenmount Medical Clinic

598 High Street Road

Glen Waverley Victoria 3150

ABN: 45 615 779 890

Phone 03 9802 9101 or 03 9802 2838

FAX 03 5296 5818

[WWW.GLENMOUNTMEDICAL.COM](http://WWW.GLENMOUNTMEDICAL.COM)

Phone 03 9802 9101 or 03 98022838

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