



Glenmount
Medical Clinic
ESTABLISHED 1958

Your Health
Our Priority

Medical History and Medical Information Release Request

To: Doctor/Clinic

Address

.....

Re: Patient's NameDOB:

Address

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 Home Medication Review

Date of Last GP Management Plan Initial (965)

Date of Last GP Management Plan Review (967)

Please send record in PDF format/XML file on Disc or email. We use Medical Director.

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:



598 High Street Road,
Glen Waverley VIC 3150



03 9802 9101



03 5296 5818



info@glenmountmedical.com
www.glenmountmedical.com