

Patient Request for Access/Release of Personal Information

Dear Doctor/Practice: _____

Address: _____

The patient below is now attending Green Tree Medical. Could you please forward details of their medical history while under your care, in the form of either a full copy of their record or an accurate summary.

IF POSSIBLE, PLEASE SEND VIA MEDICAL OBJECTS

Please also advise us of the most recent dates, any of the below assessments may have been completed:

Assessment	Date	Assessment	Date
GPMP		MHCP	
TCA		Medication Review	
45-49-Year-Old Health Check		Over 75 Health Assessment	
Asthma Cycle of Care		Diabetic Cycle of Care	
Pap Smear		Other:	

PATIENT AUTHORITY:

Patient Details (please print in block letters)	
Surname:	Given name(s):
Address:	
Date of Birth:	Phone No:

Applicant (if under the age of 16)	
Applicants full name: (if not the patient)	Relationship: (to patient)

I _____ request that a copy of my medical records be transferred to Dr Phil Parker at Green Tree Medical, for continuity of care.

Patient/applicant signature

_____/_____/_____
Date