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ABN 62 153 298 278
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BENDIGO
PRIMARY CARE
CENTRE

CONSENT TO RELEASE PATIENT INFORMATION

This form gives your consent for us to release details relevant to your care to another service. Please fill in details as required. ***Fees apply for full patient records to be released****.*

Details of Patient

Surname: _____ Given name(s): _____

Address : _____

Date of Birth: _____ Phone Number: _____

Information to be released (please tick ONLY one)

- ☐ **Full patient record**
- ☐ **Health Summary including medications and immunisations only**
- ☐ **Health Summary including medications, immunisations, correspondence and investigations from the last 3-6 months only**

Patient Consent

I, _____ give consent for BENDIGO PRIMARY CARE CENTRE to release my medical information.

Signature: _____ Date: ____/____/_____

This information is to be released to: (Name of Doctor or service)

Doctor: _____ Phone:_____

Address: _____

BPCC Doctors signature	**Patient Signature**
Doctor: _____	**Name: _____**
Signed: _____	**Signed: _____**
Date: ____/____/_____	**Date: ____/____/_____**