123 Arnold Street,
Bendigo VIC 3550
ABN 62 153 298 278
P: (03) 5441 8622
F: (03) 5441 8602

BENDIGO
PRIMARY CARE
CENTRE

CONSENT TO OBTAIN PATIENT INFORMATION

Dear Doctor: _____ Phone: _____

Location: _____ Fax: _____

_____

Details of Patient

Surname: _____ Given name(s): _____

Address : _____

Date of Birth: _____ Phone Number: _____

Information Required (please tick ONLY one)

- ☐ **Health Summary including medications and immunisations only**
- ☐ **Health Summary including medications, immunisations, correspondence and investigations from the last 3 months only**
- ☐ **Full patient record (faxed, on disc or via email in XML format)**
- ☐ **Other: _____**

Note: Please forward information in XML format (Best Practice) via email to

reception@bendigoprimarycarecentre.com.au

Patient Consent

I, _____ authorise the release of my relevant health information as specified above.

Signature: _____ Date: ____/____/_____

Requesting Physician Information

Doctor: _____

Signed: _____ Date: ____/____/_____