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):** _________________________________

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 via email to
reception@bendigoprimarycarecentre.com.au

Patient Consent

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

Signature: _______________________________ **Date:** ____/____/_______

Requesting Doctor Information

Doctor: ____

Signed: ____ **Date:** ____/____/_______