AUTHORITY FOR RELEASE OF MEDICAL RECORDS FROM SOUTHERN REGIONAL MEDICAL GROUP

Patient details:

I, __________________ **Date of Birth:** __________________

Signature: __________________ **Date:** __________________

Current Address: ____________________________________

Hereby authorise the release of my medical records to:

Practice: __________________ **Doctor:** __________________

Practice Address: ____________________________________

Phone: __________________ **Fax:** __________________

Other family members to be included:
(NB: Family members aged sixteen (16) and over to personally sign authority)

Name:	Date of Birth:	Signature (16 and over)

Please note: The release of medical records might incur an administration charge.

Attention Practice Admin:

Can see below details of any Care Plans and Recalls/ Reminders for each of the above-named patients

Care Plan/ Recall	Date last billed or Due Date	Item Number
GP Management Plan		721/732
Team Care Arrangement		723/732
Health Assessment		701/703/705/707/715
Mental Health Plan		2700/2701/2712/2715/2717
PAP Smear/ CST		
Any other recalls or reminders (e.g. skin checks, procedures, etc)		

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