AUTHORITY FOR RELEASE OF MEDICAL RECORDS TO SOUTHERN REGIONAL MEDICAL GROUP

SOUTHERN REGIONAL MEDICAL GROUP

Records coming from:

Practice: _____ **Doctor:** _____

Practice Address: _____

Phone: _____ **Fax:** _____

The patients whose details are given below are now attending this surgery.

Please forward any relevant medical history/case notes/ specialist letters/reports to assist in the patient's ongoing medical care.

I, _____ **Date of Birth:** _____

Signature: _____ **Date:** _____

Current Address: _____

Hereby authorise the release of my medical records to Southern Regional Medical Group.

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)

Attention Practice Admin:

Can you please provide details of any Care Plans and Recalls/ Reminders for each of these patients (please cross out where not applicable):

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)		

If you are using Medical Director practice software, patient records can be sent on disc in XML format.
For all other practice software please send paper copies.

Thank you.

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