PO Box 401,
Belgian Gardens Qld 4810
ABN: 111 699 321 83
Ph: 07 4771 6666 Fax: 07 4771 5566
Email: help@bgmc.com.au

____/____/____

Doctor: ______________________________

Address: ______________________________

____

Fax: ______________________________

AUTHORITY TO RELEASE OF MEDICAL RECORDS

I hereby give consent for the release of all information pertaining to my personal medical records and those of my family members as listed below from your surgery to be sent to:

- ☐ Dr Nichola O'Reilly — Provider Number: 213825DY
- ☐ Dr Fiona Fleming — Provider Number: 221383DX
- ☐ Dr Sonia Gautam — Provider Number: 4661874B
- ☐ Dr Michelle Vollmerhause — Provider Number: 247041DL
- ☐ Dr Martin Carr — Provider Number: 081061EW

Name:________________________ D.O.B. ___/___/_____ Sign________________________

Name:________________________ D.O.B. ___/___/_____ Sign________________________

Name:________________________ D.O.B. ___/___/_____ Sign________________________

Name:________________________ D.O.B. ___/___/_____ Sign________________________

Doctors Signature: ______________________________

****If you use Best Practice Software, it would be appreciated if you would export the patient records or for BP or any other software, please make a PDF file and email us the file to save on paper.****

CAN YOU PLEASE ALSO ADVISE OF ANY CDM ITEMS CLAIMED IN THE LAST YEAR.

THANKYOU.