



AUTHORITY FOR RELEASE OF MEDICAL RECORDS To GPs on Bayview

Records coming from:

Practice: _____ Doctor: _____

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: _____

Hereby authorise the release of my medical records **to** GPs on Bayview.

Other family members to be included:

(NB: Family members aged sixteen (16) and over to personally sign authority)

<u>Name:</u>	<u>Date of Birth:</u>	<u>Signature (16 and over)</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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 Please write “NIL” if no recalls)		

Please send patient records in XML format. Thank you in advance.