Landsborough MEDICAL CENTRE lmc

5 Maleny Street,
Landsborough QLD 4550

Ph: **(07) 5494 1799**
Fax: **(07) 5494 8513**

20 Karanne Drive,
Mooloolah QLD 4553

Ph: **(07) 5494 7444**
Fax: **(07) 5492 9146**

Previous Doctor Information

Practice Name: _____

Doctor: _____

Address: _____

Phone#: _____ Fax#: _____

Dear Doctor,

REQUEST FOR PATIENT INFORMATION

Patient Name: …….. DOB: …….

Patient Name: …….. DOB: …….

Patient Name: …….. DOB: …….

Patient Name: …….. DOB: …….

I, …… give permission for my/our records to be released to the above practice.

Patient Signature: …….. Date: ……

The above named patient/s is/are currently attending our practice.

Would you kindly forward a copy of the following medical history of the patient/s listed above as well as copies of any relevant correspondence and investigations.

- □ FULL SUMMARY
- □ COMPLETE MEDICAL FILE
- □ OTHER:……
  ……

Landsborough Medical Centre accepts medical records on CD in XML format.

Yours sincerely,

Doctor Name: …… Date: ……

Doctor Signature: ……