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**

Dear Doctor,

I wish to request a copy of my medical records from the Landsborough Medical Centre for my own personal use.

I understand the physical medical records & related information created & maintained for the continuing management of each patient are the property of the Practice.

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 myself.

Patient Signature: …….. **Date**: ……

Patient will collect: ☐ Landsborough ☐ Mooloolah ☐

Phone#: _____

Send via post: ☐

Address: _____

The above named patient/s is requesting their medical records.

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:……
  ……

Authorised by:

Doctor Name: …… Date: ……

Doctor Signature: ……