5 Maleny Street,
Landsborough QLD 4550

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

20 Karanne Drive,
Mooloolah Valley QLD 4553

Ph: **07 5494 7444**
Fax: **07 5494 8513**

Previous Doctor Information

Practice Name: ____

Doctor: ____

Address: ____

Phone#: ______________________________ Fax#: __________________________

Dear Doctor,

REQUEST FOR PATIENT INFORMATION

Patient Name: …………………………………………………………………… DOB: ……………………………………………….

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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/USB in XML format or via **Medical Objects**.
XML format – *Exclude (Correspondence In & Out, Clinical Images & patient photo)*

Yours sincerely,

Doctor Name: ……………………………………………………………………… Date: ……………………………………….

Doctor Signature: ………………………………………………………………