Request for Medical Records

please fax to 6122 0169
or email to reception@bellerivehealthhub.com.au

Bellerive Health Hub
MEDICAL AND ALLIED HEALTH CENTRE

Date: / /

Dear Doctor: ……..

Surgery: ……..

Phone: …… **Fax: ……**

I hereby authorise my and/or my family's medical records to be forwarded to Bellerive Health Hub.

1. Patient Name: …… Date of birth: ……
2. Patient Name: …… Date of birth: ……
3. Patient Name: …… Date of birth: ……
4. Patient Name: …… Date of birth: ……
5. Patient Name: …… Date of birth: ……

Patient or legal guardian name: ……

Patient or legal guardian signature …….. Date: ……

Note:
Please do not send original records. We prefer a Health Summary together with relevant specialist/allied health provider letters. We are an electronic practice therefore any data no longer required will be destroyed. Thank you for your assistance. Please note: we do not accept any medical records on disc.

EPC ITEM NUMBERS	IF COMPLETED PLEASE NOTE DATE AND ITEM NO.
GPMP ITEM 731 OR REVIEW GPMP 731	
TCA 723 OR REVIEW TCA 732	
MENTAL HEALTH CARE PLAN	
MENTAL HEALTH CARE PLAN REVIEW	
HEALTH ASSESSMENT	

Requesting GP Name:

Requesting GP Signature:

Date: