WEST RYDE MEDICAL CENTRE

Email: westrydemedicalcentre@yahoo.com.au

REQUEST FOR MEDICAL RECORDS

DATE: ……

I, (Name/D.O.B.)…….. of

(address)……

request my medical record be sent to:

(Doctor's name/ address/ email)

……

……

……

AUTHORITY TO OBTAIN MEDICAL RECORDS:

I hereby give permission for West Ryde Medical Centre to send my medical records to DR / Medical Centre.

SIGNED:……

DATE:……..

Admin fee: $99.00

payable to: West Ryde Radiology BSB: 062 130 Acct No: 2800 4192

Please put your name as a reference

Request to be sent by email: westrydemedicalcentre@yahoo.com.au