# ST AGNES SURGERY

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# Authority to Obtain Notes from Previous Doctor

DATE: _____ / _____ / _____

Surgery: _____ Tel: _____

Address: _____ Fax: _____

Suburb: _____ Email _____

**** PLEASE NOTE WE ARE UNABLE TO ACCEPT NOTES SENT ON A DISC or USB ****

Patient's Surname: _____ First Name: _____

Date of Birth: _____ / _____ / _____

Address Now: _____

Former Address: ***(if applicable)*** _____

**I authorise the release of my medical history to St Agnes Surgery / Tea Tree Surgery**

Names of family members also required: Signature required if over 14 years of age

Name: _____ DOB ___ / ___ / ___ *Signature:* _____

Name: _____ DOB ___ / ___ / ___ *Signature:* _____

Name: _____ DOB ___ / ___ / ___ *Signature:* _____

I/we now attend St Agnes Surgery, having formerly been a patient(s) of your Clinic. Would you kindly provide St Agnes Surgery with a summary of the relevant medical history to assist them with my/our ongoing care.

_____
**Signature of Patient**

**Office Use Only:**
□ check all sections complete
□ identification photocopied & attached
□ staff initials .....
□ patient file number .....