

Coster Street Medical Practice

(Coster Street Medical Unit Trust ABN: 55115964834)
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Dr Chris Lourensz
Dr Xavier O’Kane
Dr Natalie Yuen- Francis
Dr Shirley Cheang
Dr Luke Martin

PATIENT RECORDS REQUEST FORM

Previous Doctor _____

Previous Clinic _____

Address _____

Phone _____ Fax _____

Dear Doctor

Patient Name: _____

D.O.B _____

The above patient has elected to attend this surgery for ongoing medical care and has signed the consent to release information below. Could you please forward the following:

- **Medical history** including most recent pathology
- Specialist Letters

If applicable:

- **Date** of GP Management Plan (721)
- **Date** of Team Care Arrangement (723)
- **Date** of GP Mental Health Plan (2701)
- **Date** of GP Chronic Conditions Management Plan (965)

We use BP Premier practice management software therefore an .XML export of the patients files is our preferred format. However if this is not possible please send on a USB or CD (pdf preferred).

Thanking you in anticipation.

Yours sincerely

Dr _____

AUTHORITY TO RELEASE MEDICAL INFORMATION

I hereby authorize the release of my medical records as above to Coster Street Medical Practice.

Name _____

Signature _____ Date _____