CENTRAL HEALTH ALLIANCE

DR PAUL BURFORD
BSc MBBS MAEROMED FRACGP
Provider No.229472AL

PATIENT INFORMATION REQUEST FORM

To: Dr____________________
Practice Name: _______________________
Practice Contact Details (if known): _______________________

Dear Dr,
_______________ (patient's name) is attending Central Health Alliance and we respectfully request copies of all relevant medical information and reports that this patient has at your practice be forwarded to the address below.

Kindest regards
Central Health Alliance

PATIENT DETAILS:

Patient Name:			
Patient Address:			
Date of Birth:	/ /	**Sex:**	**M / F**

REQUESTOR DETAILS:

Doctor's Name:	Dr Paul Burford		
Practice Name:	Central Health Alliance		
Practice Address:			
Practice Contact Numbers:	**Tel:** 0459 354079	**Fax:**	02 49 829750
Practice Email Address:	manager@centralhealthalliance.com.au		
Information Requested By:	☐ Urgent (*Patient is waiting to see Dr)	☐ Non-Urgent (same day or next business day is requested)	

INFORMATION REQUESTED:

Discharge Summary:	
Investigations / Reports:	
Pathology Reports:	
Other: (specify)	

PATIENT CONSENT:

I ____________________ (the patient listed above) hereby authorise ______________________ (Doctor's name / or / Practice Name) to release my health information to **Central Health Alliance** and authorise this information be faxed to 02 49 829750 or emailed to manager@centralhealthalliance.com.au

Patient Signature: ____________________________________ Date: ____________________

CHA USE ONLY	Date Received:	Time Received:
	Staff completing request:	
	Patient information updated:	☐ Yes ☐ No