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

PATIENT INFORMATION REQUEST FORM

To: Dr _____ Practice Name: _____

Practice contact details- Ph: _____ Fax:_____

Dear Dr,

The below patient(s) is now 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.

PATIENT DETAILS:

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

REQUESTOR DETAILS:

Doctors Name:	□Dr Paul Burford □ Other _____
Practice Name:	Central Health Alliance
Practice Contact Numbers:	**Tel:** 02 4989 5100 **Fax:** 02 4989 5111
Practice Email Address:	reception@centralhealthalliance.com.au
Information requested by:	□ **Urgent** (Patient is waiting to see Dr) □ **Non-Urgent** (same day or next business day)

INFORMATION REQUESTED

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

PATIENT CONSENT:

I _____ hereby authorise _____ to release my health information to **Central Health Alliance**. I authorise this information to be faxed to **02 4989 5111** or mailed to **PO Box 5112 Raymond Terrace East NSW 2324**.

Patient Signature: _____ Date: _____