Paynesville Medical Centre			
	2/55 The Esplanade		
	Paynesville 3880		

P: 03 5156 7243 F: 03 5156 0483

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PMC

Consent for Release of Patient Information

Name:	Details of Practice/Hospito	Urgency of Re	Urgency of Request				
Attn Doctor: Image: State in the stat	Name:	Urgent	Urgent				
Phone No: Fax No: Image: Non-Urgent (within 5 business days) Dear Dactor, The below mentioned patient has recently attended this Practice. Please refer to details below regarding information required. This practice uses Medical Director V4.0 and prefers information forwarded on CD (xml format). Please do not send a disc if your practice uses Best Practice. If faxing correspondence, please fax to 03 5156 0483. Yours sincerely, Date: ////////////////////////////////////		🗌 Next Day					
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Patient Details: DOB: Address: Ph: Email: Information Required: (please tick & specify date if known – please send in .XML Format) Patient Summary Correspondence Operation Reports Investigations Investigations PATHONORY Pathology Pathology Pathent Consent Details: GPMP/TCA Rv Item 723 Date: MHCP Rv Item 2715, 2717 Date: MHCP Rv Item 2712 Date: MHCP Rv Item 2712 Date: MHCP Rv Item 999, 701-707 Date: Pathology Pathology Date: Investigations Correspondence Investigations Date: Investigations Pathology Date: Investigations Date: Investigations Pathology Date: Investigations Date: Investication Investigations	The below mentioned patient has recently attended this Practice. Please refer to details below regarding information required. This practice uses Medical Director V4.0 and prefers information forwarded on CD (xml format). Please do not send a disc if your practice uses Best Practice. If faxing correspondence, please fax to 03 5156 0483 .						
Name: DOB: Address: Ph: Ph: Email: Information Required: (please tick & specify date if known – please send in .XML Format) Patient Summary GPMP Correspondence GPMP/TCA Rv Operation Reports MHCP Investigations MHCP Rv HMR Item 721 Patient Consent Details: (Please tick & sign as appropriate) I.	Doctor:						
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Ph: Email: Information Required: (please tick & specify date if known – please send in .XML Format) Patient Summary Correspondence Operation Reports Investigations Pathology HMCP Health Assessment Item 900 Date: HMR Health Assessment Item 699, 701-707 Date: Information (including test results etc.) about my past and present illnesses to the Doctor, and other Healthcare Providers. Signed: (IPatient.] Parent or legal Representative) (Witness Name/Signature) It is impracticable to provide patient consent currently. I verify that I am treating the patient and the information is required for the patient's ongoing treatment							
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and the information is required for the patient's ongoing treatment	(Witness Name/Signature)	De	Date//				
Doctor Name: Signature: Date/							
	Doctor Name:	Signature:		Date//			

Paynesville Medical Centre endeavours to comply with the Health Records Act 2001 and other relevant legislation when handling health information. The health information enclosed is being provided to your service on the understanding that it is used for its primary purpose or a directly related secondary purpose. Disclosure of this health information to your service imposes on you an obligation to treat this information confidentially and in accordance with legislative requirements of the Health Records Act 2001 and Information Privacy Act.