Kincraig
Medical Clinic

AUTHORISATION FOR DISCLOSURE OF MEDICAL INFORMATION

Patients Full Name: _____

D.O.B: _____ Previous Practice/Doctor: _____

Other family members:

_____ D.O.B: _____
_____ D.O.B: _____
_____ D.O.B: _____
_____ D.O.B: _____

Could you please assist us by advising if the patient(s) have had any of the following assessments or reviews conducted in the last 2 years:

GPMP	Date: _____	GP Mental Health Review	Date: _____
GPMP Review	Date: _____	TCA	Date: _____
Home Medication Review	Date: _____	TC Review	Date: _____
45-49 Year Check	Date: _____	Health Assessment	Date: _____
Asthma Cycle of Care	Date: _____	Diabetes Cycle of Care	Date: _____
GP Mental Health Plan	Date: _____		

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*The above patient is now attending the **KINCRAIG MEDICAL CLINIC** and has requested that copies of relevant information from his/her medical history be forward to us. This will greatly assist us with further management.* ***Please DO NOT send information via disc.***

Yours faithfully,

Dr _____ ***Signature:*** _____

I, the above name, authorise the release of Medical Information from my files at your surgery to be sent to the below address.

Patients' signature: _____

6 Cedar Avenue, Naracoorte, SA 5271 Email: kincraigmc@kmc.com.au P. O. Box 597 Naracoorte, SA 5271
Ph. 08 8762 4888 Fax. 08 8762 1169 ABN. 23 869 764 477