Hamilton Medical Group

HAMILTON MEDICAL GROUP PARTNERSHIP

Dr A M McAllan Dr L J Walker Dr A E Reid
Dr J H Slabbert Dr D R Ford Dr A J Bowman *(Consultant Physician)*

HAMILTON MEDICAL GROUP ASSISTANTS PTY LTD

Dr A L U Teo Dr R Joyce Dr K S Silva *(Consultant Physician-Geriatrician)*
Dr A Tai Dr J C de Kievit Dr M F McVeigh *(Consultant Physician-Neurologist)*
Dr R Lunz *(GP Reg)* Dr S M Robertson Dr Y Yoshimitsu *(GP Reg)*
Dr R Jaipurwala *(GP Reg)*

………/………/20……..

Doctor ______________________

Clinic ______________________

Address ______________________

Suburb & Postcode ______________________

Telephone & Fax Tel: Fax:

Patient Name ______________________

Patient Date of Birth ______________________

Patient Current Address ______________________

Patient Former Address ______________________

Associated family members (if relevant):

NAME	DOB	Signature (over 16 years must sign)

The above patient(s) has/have presented to the Hamilton Medical Group for care.
I would be grateful if you would forward any relevant details of their medical history at your convenience. **Please do not forward the information on a CD.** Thanking you in anticipation.

Yours sincerely

Dr …………………………

Patient's Authority to Release Medical Records:

I hereby give permission for the Hamilton Medical Group to obtain medical records on my behalf.

Signed: ……………………………………………………..

Date: ………/…………/20……

Forms/patient authority to release medical records

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A fully Accredited General Practice