Date:

To Brighton Family & Women's Clinic

Patient Name:
Address:
Phone:
Date of Birth:
Medicare No.:

The patient named above requests their medical record.

Other members of the family (under the age of 18) whose record requires to be transferred:

****PLEASE NOTE: Patients aged 18 and older must complete and sign their own form****

Patient Name	Date of Birth
_____	_____
_____	_____
_____	_____

Patient's Authorisation:

I hereby give authority for the above mentioned medical records to be provided to me/my family.

Patient's signature:

Witness:

Thank you for your co-operation in this matter.