2b Murray Street
PO BOX 194 GAWLER 5118
Tel: (08) 85221844
Fax: (08) 85230366
Email: reception1@gawlermedical.com

GAWLER MEDICAL CLINIC

Date : …….

To: ……

……

……

Dear Doctor

Re: ……..…….. D.O.B……

Address:…….……

…….. D.O.B……

Address……. …….

The above patient (s) is/are attending this Clinic. It would be appreciated if you could supply a copy or summary of any relevant medical records you may have on the above named. This surgery uses Best Practice software and is unable to accept records on discs using Medical Director.

Could you please advise us of the dates of any:		Date last billed
Care Plans including reviews	721, 723, 732	_ _ / _ _ / _ _ _ _
Health Assessments	700/702	_ _ / _ _ / _ _ _ _
Home Medication	900	_ _ / _ _ / _ _ _ _
Mental Health Plans	2710/2712/2713/2702	_ _ / _ _ / _ _ _ _

Yours faithfully

For GAWLER MEDICAL CLINIC

Permission for release of medical records:

I _____ agree to the release of all my medical records from your clinic to

Dr John Salagaras
Dr Adrian Borg
Dr Rose Tiong
Dr Estelle Smit
Dr Sandra Marshall
Dr Samantha Davis
Dr Emad Ehsan
Dr Sau Peng Cheah
Dr Kirsten Due
Dr Jaswinder Kaur
Dr Elaine Rodgers

Signed……. Dated……