2b Murrray 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……

……D.O.B…….

……..D.O.B……

……..D.O.B……

The above patient (s) is/are attending this Clinic. It will be appreciated if you can supply a copy or summary of any relevant medical records you may have on the above named.

Please note, our surgery uses Best Practice software and would prefer files on disc or USB in XML format. We are 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 Elaine Rodgers
- ☐ Dr Josiah Salagaras
- ☐ Dr Emad Ehsan
- ☐ Dr Sau Peng Cheah
- ☐ Dr Sandra Marshall
- ☐ Dr Iqbal Muhamad

Signed……. Dated……