

# Marendy Medical Services Inc Redcliffe Medical Clinic

## Patient Health Information Request

Please complete this form if you would like a copy of your health records sent to Redcliffe Medical Clinic from a previous health professional or organization you have attended

PATIENT'S DETAILS			
Given names:		Surname:	
Date of Birth:		Phone No:	
Street and Number:			
Suburb:		Postcode:	
DETAILS OF YOUR CHILDREN AGED UNDER 18 YEARS (if their records are also being requested)			
Name:		Date of Birth:	
Name:		Date of Birth:	
Name:		Date of Birth:	
DETAILS OF THE PREVIOUS HEALTH PROFESSIONAL/ORGANISATION			
Name:			
Street and Number:			
Suburb:		Postcode:	
PATIENT AUTHORITY: Please forward copies of all relevant medical records relating to me (and/or my child, if applicable) to Redcliffe Medical Clinic for my/our future care			
Print name of person completing this form (note you cannot sign for your spouse or adult children):			
Signature:		Date:	/ /

Please send a copy of the following documents:

Patient Health Summary	Specialist Reports	Relevant Investigations etc
Immunisations	Mental Health Care Plans	Other:
Discharge Summaries	Chronic Disease Care Plans	Full Record -incl all of above

**Please note:** We can receive secure messages via Medical Objects or Healthlink

If this is not possible, we would appreciate a **Patient Health Summary sent by fax ASAP** or the full record either faxed or sent via mail.

Please contact us with any queries. Thank you for your prompt co-operation.

**Redcliffe Medical Clinic**  
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Redcliffe Q 4020

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