KENOLTA
MEDICAL CENTRE

T 02 5104 3966 **F** 02 5104 3818 **E** reception@kenolta.com.au
9/34-38 O'Hanlon Place, Nicholls, ACT 2913
www.kenolta.com.au

Personalised, holistic care with excellence

Dear Responsible Officer

Practice Name……..

Phone Number……

Fax Number……..

Name of regular Dr/Clinician (if applicable) ……

REQUEST AND AUTHORIZATION TO RELEASE MEDICAL RECORDS

Kindly note that the individual(s) listed below are either patients / or intending to become patients at KENOLTA Medical Centre, Nicholls.

Patient Name(s)	Date of birth	Patient Signature (for all patients 16yrs & above)

For the purpose of a timely continuity of care, I / we hereby request and authorize an immediate release to KENOLTA Medical centre (via post to the address listed above), all relevant copies of:

(i) a full / complete medical records in your custody for all listed individuals

OR

(ii) specific records (if there are any details listed below)

…….
…….
…….

Please send an electronic copy of all records where possible.
KENOLTA Medical Centre utilises Best practice Medical software.

If required, please contact me directly to discuss any reasonable fees.

Name…….

Signature……Date……..