**Sherbourne Road Medical Clinic**

**111 Sherbourne Rd. Montmorency 3094**

**P.O. Box 61, Briar Hill 3088**

**Telephone: 9435 1144 Fax: 9432 8687**

**info@sherbourneroadmc.net.au**

**www.sherbourneroadmc.net.au**

 **To: Dr…………………………………………………………………….**

 **At: ………………………………………………………………………..**

 **………………………………………………………………….…….**

 **Fax: ………………………………………………………………………**

 **Re: ………………………………………… DOB : …………………….**

The patient above has attended this clinic.

In order to assist with his/her future management, we would be pleased if you would forward a copy of the patient’s history and any relevant investigation results and correspondence.

We are a paperless clinic, if you are using Medical Director medical software, we request the file delivered on a **disk in XML format**.
If you are using Best Practice medical software, we request the file delivered on a **disk in HTML format with documents attached, we cannot import HTML but can use the attached file documents. (XML does NOT import to MD software by BP at this stage.)**

**Patient Consent:**

I hereby request and provide my written consent for release of details of my past medical history and treatment to:

Dr………………….…………………..
@ Sherbourne Road Medical Clinic, 111 Sherbourne Road, Montmorency, 3094.

Yours sincerely

Patient

Signature: ……………………………………… Date: …………………………………