**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 to record your medical records we would prefer the file delivered on a **disk in xml format**.

\*\*Please note – if you are using Best Practice software, we cannot accept disk in XML format. You may export medical history in HTML format instead. Please call our clinic if you are unsure and wish to discuss.

**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: …………………………………