PIONEER HEALTH
ALBANY

2 Pioneer Road
Albany WA 6330
Phone 08 9842 2822
Fax 08 98428219
Healthlink: PIONEERH
admin@pioneerhealth.com.au
www.pioneerhealth.com.au

Authority to Release Medical Records FROM Pioneer Health

Patient name: ____

Date of birth: ____

Address: ____ Postcode:________

Medicare No: ____

I hereby authorise the release of my medical records from Pioneer Health Albany to:

____

[Insert practice name to send records to]

Signed ________________________________ Dated_____ / _____ / _____

Other family members to be included:

Name ________________________________ Date of birth_____ / _____ /_____

Signed ________________________________ Dated_____ /______/ ______

Name ________________________________ Date of birth_____ / _____ /_____

Signed ________________________________ Dated_____ /______/ ______

Name ________________________________ Date of birth_____ / _____ /_____

Signed ________________________________ Dated_____ /______/ ______

[more space overleaf]

2 Pioneer Road
Albany WA 6330
Phone 08 9842 2822
Fax 08 98428219
Healthlink: PIONEERH
admin@pioneerhealth.com.au
www.pioneerhealth.com.au

Name ________________________________ Date of birth_____ / _____ /_____

Signed _______________________________ Dated_____ /______/ ______

Name ________________________________ Date of birth /______/ ______

Signed _______________________________ Dated_____ /______/ ______

Name ________________________________ Date of birth_____ / _____ /_____

Signed _______________________________ Dated_____ /______/ ______

Name ________________________________ Date of birth_____ / _____ /_____

Signed _______________________________ Dated_____ /______/ ______

Name ________________________________ Date of birth_____ / _____ /_____

Signed _______________________________ Dated_____ /______/ ______