123 Arnold Street,
Bendigo VIC 3550
ABN 62 153 298 278
P: (03) 5441 8622
F: (03) 5441 8602

BENDIGO
PRIMARY CARE
CENTRE

CONSENT TO OBTAIN PATIENT INFORMATION – MULTIPLE CHILDREN UNDER 16

Dear Doctor: _____ **Phone:** _____

Location: _____ **Fax:** _____

_____

Details of Patient

Surname: _____ **Given name(s):**_____ **D.O.B:**_____

Surname :_____ **Given name(s):**_____ **D.O.B.**_____

Surname :_____ **Given name(s):**_____ **D.O.B.**_____

Address : _____

Phone Number: _____

Information Required (please tick ONLY one)

- ☐ **Health Summary including medications, immunisations, correspondence and investigations from the last 3 months only**
- ☐ **Full patient record (faxed, on disc or via email in XML format)**
- ☐ **Other:** _____

Note: Please forward information in XML format (Best Practice) via email to **reception@bendigoprimarycarecentre.com.au**

Parent/Guardian Consent

I, _____ **authorise the release of my relevant health information as specified above.**

Signature: _____ **Date:** ____/____/_____

Requesting Physician Information

Doctor: _____

Signed: _____ **Date:** ____/____/_____