Northside Clinic
Patient Information Request Form

Patient Details

Patient Name .....

Date of Birth .....

Address .....

.....

I, the above named patient consent to the release of health information regarding my previous care at the practice detailed below to Northside Clinic. I understand this is necessary for my ongoing treatment.

Patients Signature .....

Date .....

Name: (if different to the patient) .....

Relationship to the patient .....

Previous Provider Details

Provider Name .....

Hospital/Practice/other .....

.....

Phone ..... Fax .....

Urgency of request Urgent Next Day Non-Urgent (within 5 business days)

Please post a CD, fax or use secure electronic encryption to send the medical records to:

Northside Clinic

Attention: .....

370 St Georges Road Fitzroy North VIC 3068

Fax 03 9486 5718

Results can be sent via argus on argus@northsideclinic.net.au or via healthlink

Please Note: If you are sending via CD we can only accept PDF or Genie Format.