epiclinic®
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Email: reception@epiclinic.com.au

Request and Consent – Release of Medical Records

Release to: _____

Phone: _____ Fax: _____ Email: _____

I hereby request Epiclinic to release my medical records to the above-mentioned person/clinic as per the details outlined below:

Please include:

☐ Medical Notes Regarding Specific Health Concern:

☐ Reports

☐ Pathology

☐ Imagery

☐ Other: _____

Patient Consent:

I/We give permission for my/our medical records to be transferred to the above-mentioned person/clinic.

Patient Name: _____ DOB: _____ Minor: Yes / No

Date: _____ Signature: _____ Parent/Guardian: _____

Doctor Name: _____ **Doctor Signature:** _____