• HEALTH AND WELLBEING •
WULGURU MEDICAL CENTRE

Address: Unit 1, 346-348 Stuart Dr
Wulguru, QLD 4811
Ph: (07) 4778 3355
Fax: (07) 4778 3420
Em: reception@hwbw.com.au

AUTHORITY TO RELEASE MEDICAL INFORMATION

TO:

Doctor: **Medical Practice:**

Phone: **Fax:**

PATIENTS:

1. Name:_____ DOB: ____/____/____
2. Name:_____ DOB: ____/____/____
3. Name:_____ DOB: ____/____/____
4. Name:_____ DOB: ____/____/____
5. Name:_____ DOB: ____/____/____

REQUESTING:

☐ Health Summary

☐ Records of care from _____to _____only.

☐ Records of care concerning the following condition(s)_____

☐ Other: Specify: _____

☐ Confer with other person orally about information in my medical record.

I do hereby authorise and direct you to release my medical records to Health and Wellbeing Wulguru, Unit 1, 346-348 Stuart Drive, Wulguru, QLD 4811, as I am now attending this medical practice.

Name (printed)_____ Patient Signature:_____ Date: ____/____/____

Name (printed)_____ Patient Signature:_____ Date: ____/____/____

*If you are 16 or over you need to sign yourself.

www.healthandwellbeingwulguru.com.au

Document title: Authority to Release Medical Information
Reviewed by: Kea Jones / Practice Manager
Version 2.01 | Effective Date: 04.08.2025 | Next Review Date: 04.08.2026