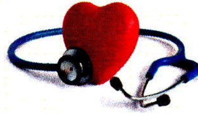

NORTHEND MEDICAL CENTRE

48-50 CHILDS ROAD, EPPING VIC 3076
TEL: 9408 8800 FAX: 9408 882

Dear Doctor,

Re:

Date of Birth:

Address:

Previous Address (if had changed address recently):

____

The above named patient has decided to seek medical care at **Northend Medical Centre.** We would appreciate if you could provide a copy of their medical history and any other relevant information for our records.

Could you also forward a copy of medical history for the following immediate family members;

Name:__________________________________ Date of Birth: __________

Name:__________________________________ Date of Birth: __________

Name:__________________________________ Date of Birth: __________

Yours Sincerely,

DR.
NORTHEND MEDICAL CENTRE

Patients Authorisation

I,______________________________, authorise the above mentioned Doctor to obtain the medical records as requested.

Signature:_______________________ Date:____/____/______