|  |  |  |  |
| --- | --- | --- | --- |
| **Patients Name & Address:**  ……………………………………..  ……………………………………..  …………………………………….. | **D.O.B:**  ………./………./………. | **Doctors Surgery:**  ……………………………………..  ……………………………………..  …………………………………….. | **Surgery Phone/Fax Number:**  ……………………………………..  ……………………………………..  …………………………………….. |

AUTHORITY TO OBTAIN MEDICAL RECORDS

**The below-named patient wishes to participate in the ITC (Integrated Team Care) Program with this practice. Would you kindly forward copies of any relevant medical history as soon as possible. Please find below an authority permitting us to request the records concerned.** *(Please tick & circle appropriate document type)*

|  |  |  |  |
| --- | --- | --- | --- |
| 🞏 Care Plan/Review | 🞏 Team Care Arrangement | 🞏 GP Management Plan | 🞏 715 Health Assessment |
| 🞏 Other (*please specify) ­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | | | |

Kind Regards,

**🞏** Valerie Pilcher **🞏** Allannah Munro **🞏** Alma Hawdon **🞏** Thelma Fry 🞏

Executive Manager Primary Health Care Manager Care Co-ordinator Outreach Worker Outreach Worker

**I hereby give permission for the Aboriginal and Torres Strait Islander Community Health Service Mackay Ltd to obtain my medical records from your clinic.**

**Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sign: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Aboriginal & Torres Strait Islander Community Health Service Mackay Ltd ● 31-33 Victoria St. Mackay QLD 4740 Phone: (07) 4957 9400 ●

Clinic Email: itc@atsichs.org.au ● ABN: 81 625 886 73

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