CAMBOURNE CLINIC

FREEDOM OF INFORMATION

PARTNERS

DR A.J CHOW M.B.,B.S.,F.R.A.C.G.P

DR T.J SLATTERY M.B.,B.S.,D.R.A.N.Z.C.O.G.,F.R.A.C.G.P

DR K.E CARISON M.B.,B.S.,B.Med.Sci.,F.R.A.C.G.P

DR C.W FAIRBROTHER M.B.,B.S.,B.V.Sc.,F.R.A.C.G.P

DR J.M DWYER M.B.,B.S., D.C.H.,F.R.A.C.G.P

ASSOCIATES

DR M.A DUNKLEY M.B.,B.S.,D.R.A.N.Z.C.O.G.,F.R.A.C.G.P

DR D BENNETT M.B.,B.S (HONS) B.Med. Sci.

DR R.M BASSETT M.B.,B.S.(HONS), D.C.H.,F.R.A.C.G.P

DR C.E FINNIGAN M.B.,B.S., F.R.A.C.G.P.

DR M SHRESTHA M.B.,B.S

DR J SONG M.B.,B.S

DR R CASTORANI M.B,B. S

DR M CHENOWETH M.B.,B.S

DR H CUTTING M.B.,B.S

DR C YAO M.B.,B.S

DR C SILVA M.B,B.S

Request for Medical Records

Please complete if you are now attending Cambourne Clinic and would like a copy of your medical records sent to us.

Date: _____

Details of Previous Clinic: _____

Address: _____

_____

Phone: _____ Fax:_____

Email: _____

Patient Authority to Release Information for Medical Records

I hereby give authority to Cambourne Clinic to obtain relevant medical records.
Patients over 16 years of age MUST sign to authorise transfer of their medical records.

Name: _____ D.O.B: _____ Signature: _____

Name: _____ D.O.B: _____ Signature: _____

Name: _____ D.O.B: _____ Signature: _____

Name: _____ D.O.B: _____ Signature: _____

Name: _____ D.O.B: _____ Signature: _____

FREEDOM OF INFORMATION

Previous clinic to complete:

GPMP/TCA: Date: _____ Item Billed: _____

MHCP: Date: _____ Item Billed: _____

Health Ass: Date: _____ Item Billed: _____

Other Recalls: _____

Please send via E-REFERRAL (cambourneclinic)
or DISC in PDF or JPG format.
No XML files unless with attached HTML file.

telephone. 03 5561 2077 | facsimile. (03) 5561 2829 | email. office@cambourneclinic.com.au

website. cambourneclinic.com.au | address. 196a Liebig Street Warrnambool VIC 3280