



# URANGAN Medical Centre

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Dr Davood Mafi Provider No. 1568201F

## Patient Request for Access / Release of Personal Health Information

Dear Doctor / Practice Name: .....

Phone No: ..... Fax No: .....

The patient below is now attending our medical practice. Could you please forward details of their medical history with you, in the form of either a full copy of their record or an accurate summary to the doctor mentioned above, who is now responsible for their ongoing care.

**If your practice uses Medical Director, we would be happy to receive the electronic data via Medical Objects / CD in XML format.**

**For practices using Best Practice, please create the file in PDF.**

Where appropriate, could you please also provide is with a scanned copy of the following, completed table:

Assessment	Date	Assessment	Date
GPMP		Medication Review	
TCA		Annual Diabetic Cycle of Care	
Over 75 Health Assessment		45-49 Year old Health Check	
HP Mental Health Treatment Plan/Review		Specialist Review	
Pap Smear		Other	

### PATIENT AUTHORITY

Patient's Name: ..... Date of Birth: ..... / ..... / .....

Address: .....

I request that you forward details of my medical treatment with you to the doctor mentioned above, who is now responsible for my ongoing care.

I authorise the doctor / practice named above to provide a copy or summary of my health records.

.....  
Patient signature

.....  
Dr Shahzad Ahmed

.....  
Date