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PIONEER HEALTH - ALBANY

Authority to Release Medical Records

To: Dr ______________________________________

Address:__________________________________

____________City: __________ P/C: __________

Fax: _____________________

Dear Doctor

The patient whose details are given below is now attending this surgery for regular medical attention.

I would be grateful if you could forward any relevant medical history / case notes / specialist letters / reports to assist in this patient's ongoing medical care. **If your practice currently uses Medical Director 3 it would be greatly appreciated if you could forward these notes on disc.**
Thank you for your assistance.

Yours faithfully,
Pioneer Health Albany

I _________________________________Date of birth______/_____ /________

Signed: ___________________________ Dated: _________________________

hereby authorize the release of my medical records to Pioneer Health Albany.

Other family members to be included:

Name: _________________________ Date of birth: _____/______/__________

Signed: _________________________ Dated: __________________________

Name: _________________________ Date of birth: _____/______/__________

Signed: _________________________ Dated: __________________________

Could you also please also advise us of the most recent dates when any of the following items were charged.

Mental Health Care Plan: _______________________________

2700,2701,2712,2713,27158,2717_________________________

Health Assessment: 701,703,705,707,715___________________

GPMP/TCA: 721,723,732________________________________

DMMR:900____

PIP incentive items: 2497 to 2559_______________________

Date of Last Pap Smear:____________________