



Shop 4, 60 Lloyd Avenue
Ravenswood WA 6208
Phone: 9582 4998 **Fax:** 9582 4997

Email Medical Records Consent Form

This consent form is used to request medical records to be received by a specific patient to a specific email address.

Patient Full Name	
Patient Date of Birth	
Patient Address	
Patient email to be used	

CONSENT:

I hereby give permission for release of my medical records to the above email address, staff have informed me of possible privacy risks due to the use of email and electronic communications.

Patient Name	
Patient Signature	
Date	

Please note: Anyone aged 18 or over must sign their consent for the release of medical records

Office use only:

Employee Responsible:	
Date Sent:	