Southern Women's Health

AUTHORITY TO RELEASE MEDICAL INFORMATION

Name of practitioner: Dr Danielle Sammut

Address: Southern Women's Health

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Re: **Name:** ________________________________

DOB: __________________________________

I hereby authorise ____[name of company/individual] of

____[Address], to provide copies of my medical records to Dr Danielle Sammut at Southern Women's Health whose details are noted above.

The documents required:

Patient Medical Summary ☐

Other ☐ ________________________

Recent CST result ☐

Recent Pathology results ☐

Specialist letters ☐ ____________________________________

Mental health care plan ☐

Signature: ……………………………………………………

Date: …………………