Oxford Street Medical Centre

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Dear Doctor,_____

Dr's Address, _____

Suburb: _____ Post Code: _____

Phone: _____ Fax: _____

Patients Name: _____ DOB: _____

(Children under the age of 16, who will be attending this practice.)

Children: _____ DOB: _____

Children: _____ DOB: _____

Children: _____ DOB: _____

The above mentioned patient is / patients / are now attending this practice and have requested that we seek from you a copy of their medical history, lab report and any relevant letters.

We run Medical Director at this practice. **If sending via CD please make it a XML file so that we can import directly into the patient's file.**

Yours sincerely,

Dr Jack O'Connor **Dr Sue Martin** **Dr Sue Clarke** **Dr Corin Sprod**
Dr Laura O'Connor **Dr Melissa Erkins** **Dr Victoria Blackwell**

I, _____ give my permission for my /

our medical records to be released.

Signed: _____ Date: _____