

Dr Gerald Murphy  
Dr Prashanthi Godakumbura  
Dr Samsun Nahar  
Dr Sujay Ganganaghata Chandraiah  
Dr Nisha Rajee  
Dr Marina Messak



Phone: (03) 5022 1488  
Fax: (03) 5023 6838

Doctor/Clinic: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Fax: \_\_\_\_\_

\_\_\_\_\_

I hereby request and authorise the release of my medical records or a medical summary to:

**Deakin Medical Centre - 255 Deakin Avenue Mildura, Vic. 3500**

**PATIENT NAME:** \_\_\_\_\_ **D.O.B:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **SIGNED:** \_\_\_\_\_

**CURRENT ADDRESS :** \_\_\_\_\_

**PREVIOUS ADDRESS:** \_\_\_\_\_

Can you please advise the date of any of the following assessments/reviews completed whilst the patient was under your care.	Item	Date Last Billed
	GPMP (Item 721)	_____
	GPMP Review (Item 732)	_____
	TCA (Item 723)	_____
	CMA (Item 701/703/705/707)	_____
	Home Medication Review (Item 900/903)	_____
	Health Assessment (Item 701/703/705/707)	_____
	Mental Health Care Plan/Review (Item 2700/2712/2715/2717)	_____

**Witness Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Please send XML file from Best Practice or Medical Director via post on USB or CD or email to carolyn@deakinmedical.com.au**