Broome Regional Aboriginal Medical Service
P.O.Box 1879, Broome, W.A. 6725
Ph: (08) 9192 1338 Fax: (08) 91923 1606

PATIENT RELEASE OF MEDICAL INFORMATION

Date: _____

To: _____

_____

Re: _____

Of: _____

D.O.B: _____

The above named patient/s is now attending this practice.

Would you please forward details of his/her medical records.

Please find below a consent form signed by the patient.

Thank you.

Dr. _____

BROOME REGIONAL ABORIGINAL MEDICAL SERVICE

I _____ consent for my medical records to be released to B.R.A.M.S.

Patient Signature: _____ Date: _____

AN ORGANISATION OF ABORIGINAL PEOPLE, FOR ABORIGINAL PEOPLE, CONTROLLED BY ABORIGINAL PEOPLE.