FM026 REQUEST FOR COLLATERAL MEDICAL INFORMATION FORM

Date _____

Toowong Private Hospital
496 Milton Rd Toowong
Ph. (07) 3721 8000

To: _____

_____

_____

Re: _____ DOB: _____

The abovementioned is currently an inpatient at Toowong Private Hospital. Could you please forward any prior summaries regarding previous treatment and admission to:

Fax: (07) 3721 8099 or **Email:** tph@toowongprivatehospital.com.au

I am particularly interested in:

_____

_____

_____

_____

_____

_____

Sincerely,

_____
Print Name

_____ _____
Signed Date

Patient Consent

I, _____, Consent to the release of the above information to Toowong Private Hospital.

_____ _____
Signed Date