

## Transfer of Health Summary Consent Form

I,  give consent for my Health Summary  
(or other medical records as requested below) to be released to Tetra Health Clinics.

Patient DOB (dd/mm/yyyy):

Patient Address:

  

**Patient Signature**

**Date** (dd/mm/yyyy)

**Please include the following:**

- Health Summary  
 Specialist Letters

**Notes / Other:**

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**I authorise for this release to be;**

- Faxed to Tetra Health  
 Sent by email to Tetra Health

*(Please select one or both)*