epsilonclinics
Where Wellness Blooms

TRANSFER OF HEALTH SUMMARY CONSENT FORM

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

Patient DOB (dd/mm/yyyy): / /

Medicare / IHI:

IRN

Patient Address:

State:

Postcode:

Ph:

Please include the following:

- Health Summary, **including diagnosis and medications trialed**
- Specialist letters (optional)

NOTES/OTHER:

I authorise for the release of my records to be sent by email to Epsilon Clinics.

Patient Signature

Date (dd/mm/yyyy) / /

Please send patient health summary form to patients@epsilonclinics.com.au