25 Osborne St.
Wollongong 2500
Phone: 42263088
Fax: 42271606
www.idlc.com.au

Medical Record Request Form

Name:

Date of Birth:

Gender:

Address:

I give my consent for my medical record to be forwarded electronically to the following. Please select one.

a) My current treating Dermatologist at a new location
b) A new consultant dermatologist
c) Myself

Email address to send medical record:

Paper copies attract a fee of $40 to be paid prior to release:

Signed:

Dated: