



**FM026 REQUEST FOR COLLATERAL MEDICAL INFORMATION FORM**

Date \_\_\_\_\_

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](mailto: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 \_\_\_\_\_

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**If you receive this document in error, please contact us immediately on (07) 3721 8000.**