

PATIENT AUTHORITY - Consent for Sharing of Medical Records

Client to complete

I, _____ Pronouns _____
(Preferred name of client)

of, _____
(Address of client)

Date of birth: _____

Authorise, _____
(Name of GAHT prescriber & Clinic)

Phone number: _____ Fax number: _____

to release my medical information to:

Your Community Health
East Reservoir Clinic

Client Signature: _____

Date: / /

GAHT – External Prescriber Safe Access Form

Prescriber to complete

Prescriber name				
Clinic name & address				
Endocrinologist name & contact details (if applicable)				
Medical history				
Current medications				
Medication (name & dose)				
Date prescribed				
Current dose interval (weeks)				
Date GAHT initiated				
Date of last GAHT administration				
Last blood test date				
Relevant results	Oestradiol	Free testosterone	Testosterone	HCT
Next blood test date				
Current blood test interval				
Next appointment date with prescriber				



Your Community Health
125 Blake Street, East Reservoir VIC 3072
T (03) 8470 1111 F (03) 8470 1107
medical.admin@yourch.org.au or
practicenurse@yourch.org.au

GAHT – External Prescriber Safe Access Form

Prescriber to complete

I, _____
(Prescriber name)

Consent to the administration of the above listed GAHT at **Your Community Health**, to,

(Legal name of client & date of birth)

Prescriber Signature: _____

Date: _____