



Dear Dr. _____

Re: _____ DOB _____

I will be attending the Ibuki Health and Wellness Clinic and wish to have a copy of my records forwarded to them for my ongoing medical care.

I, _____ hereby give you permission to forward my medical records to Ibuki Health and Wellness as detailed below.

Signed: _____

Dated: _____

Fax (07) 5447 5690
Email: info@ibukihealth.com.au
Address: PO Bopx 108, Noosa Heads, 4567

Ibuki Health & Wellness, 71/6 Quamby Place, Noosa Heads, Qld, 4567
Phone: 07 5447 5679 Fax 07 5447 5680