REQUEST FOR TRANSFER OF MEDICAL RECORDS

Dear Doctor,

Please arrange for the transfer of medical records as authorised below

Patient: Mr / Master / Mrs / Ms / Miss / Other: _____

First Name _____ Middle Name _____

Last Name _____

Home Address _____

_____State _____Postcode_____

Date of Birth ___/___/____ Contact telephone number_____

Patient Authorisation:

To release copies of my medical records

I hereby authorise Dr/Practice name _____

Address _____

Please send a copy of Medical Records including:

- Patient history summary inclusive of medication, allergies, immunisations
- Recalls
- Minimum of 12 months of correspondence and investigations
- GPMP/TCA, Cycle of care, MHCP, Health assessments, **if these item numbers apply to the patient please provide the last billing date.**
- **xml format preferred**

Doctors Corner

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practicemanager@doctorscorner.com.au

Signed

_____

Patient/ Guardian Signature

Date ____/____/____