Patient file transfer request

To: Dr. _____

Practice: _____

Address: _____

_____

Fax: _____ Ph: _____

Re: Name: _____

DOB: _____

Address: _____

_____

Additional family members to be transferred (signature required if over 18)

Name _____ DOB / / Signature_____

Name _____ DOB / / Signature_____

Name _____ DOB / / Signature_____

The above mentioned is now attending this practice. Would you kindly forward their clinical records or an accurate health summary, with relevant correspondence and results, to assist in the future management of this patient. These records can be forwarded by mail, fax or exported onto CD using XML format. The patients signed authority appears below.

PATIENT AUTHORITY

I hereby request and authorise the release/ transfer of my medical history to Local Doctors.

Signature: _____ Date: _____

Office use only

Date sent _____ Sent by: _____ Initial _____