Transfer of Medical Records

Date: _____

TO:

Name of practitioner: Dr _____

Practice Name: _____

Practice Address: _____

Practice Tel: _____

Practice Fax: _____

REQUESTED BY:

I request that a copy of my medical history be forwarded to the doctor listed below.

Name: _____ Date of Birth: _____

Address: _____

Signature: _____ Tel: _____

Could you please include other members of my family as listed: (less than 16 years old)

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

RECORDS TO BE FORWARDED TO:

I request that a copy of my medical history be forwarded to the doctor listed below.

Name: Dr _____

Name of practice: Gordon Medical Centre _____

Address: 772A Pacific Highway Gordon NSW 2072 _____

Telephone: (02) 9499 9999 _____

Fax: (02) 9499 8999 _____

If there is a charge for the transfer, please invoice me (the patient) directly. Paper or Electronic format in HTML, XML and other PC formats are accepted.

OFFICE USE ONLY	
	Date
Sent	
Received	
Input	
Scan	
Archive	