Request for Medical Records Transfer

Address: Spring Farm Shopping Centre,
254 Richardson Road
Spring Farm, NSW 2750
Ph: (02) 4622 1440
Fax: (02) 8039 7446
Email: info@springfarmmedical.com.au
Website: www.springfarmmedical.com.au

Date: __/__/____

Dear

Patient Full Name	**Address**	**DOB**

Other Family Members *(if under 18 years of age)*	**Address**	**DOB**

The above mentioned patient(s) is now being treated at this practice. To assist in the future medical management, we would kindly asked you to forward the following:

- ☐ Clinical records
- ☐ An accurate health summary, with relevant correspondence and results
- ☐ Details of any CDM or PIP items claimed within the last 2 years

These records can be forwarded by mail, fax, email or an option more suitable to you.

Kind regards,

Dr.

PATIENT'S SIGNED AUTHORITY

I………………………………………… *(patient's full name)*

of………

(patient's current address and date of birth)

authorise the release of my/my families' medical records to be forwarded to Spring Farm Medical Centre.

Signed: ________________________________ Date: ______________________