Request of Medical Records Transfer

Date: _____

Practice Name Releasing Medical Records: _____

Fax or email: _____

Dear Doctor,
As the patient listed below now attends this practice, please forward a copy of their medical records (or a complete and accurate health summary) and any other relevant clinical information to assist in the continued management of their healthcare.

Patient (full name): _____

Address: _____

Date of Birth: _____

Patient consent

I, _____ consent to the release of my medical records and any other relevant clinical information to **East Hills Medical Centre**.

Signature: _____ Date: _____

If not patient signing – name: (please print) _____

Your relationship to patient: (e.g. Mother, Father, guardian, carer)_____

Yours sincerely,
Practice Manager
East Hills Medical centre
Shop-1, 17 Maclaurin Avenue, East Hills NSW 2213
Tel: 02 97733676
Fax: 02 97733884
Email: info@easthillsmedical.com.au
www.easthillsmedicalcentre.com.au

Please send them in an .xml format in a CD or USB.