To Whom it May Concern

REQUEST FOR TRANSFER OF MEDICAL RECORDS

To:____

Email/Phone:____

Please arrange for the transfer of medical records as authorised below.

PATIENT:

First Name_____________________________ Middle Name _______________________________

Last Name ____

Home Address ____

State ______ Postcode ___________ Date of Birth _____/______/________

Contact Telephone Number _____________________________________

Other Family Members / Dependants (SIGNATURE REQUIRED FOR 16YO AND OVER)

Name____________________________ DOB________________ Signature___________________

Name____________________________ DOB________________ Signature___________________

Name____________________________ DOB________________ Signature___________________

Name____________________________ DOB________________ Signature___________________

If the patient has had a GP Management Plan, Team Care Plan Arrangement, Health Assessment or Mental Health Care Plan completed at your Practice could you please send the most recent of these documents.
For the female patients, could their Pap Smear results also be included.

To release copies of my medical records to:

ERIC STREET MEDICAL
4/36 Eric Street, Cottesloe 6011 WA
P: (08) 6314 1161 F: (08) 6314 1162
E: reception@ericstreetmedical.com.au

Note: We use Best Practice and prefer emailed records in XML format (if you are unable to email in XML format, please post USB or DISC containing records in XML format.)

Signed

_____________________________ Date _____/______/_______

Patient/Guardian Signature