



Request for Medical Records Transfer

My Family Health Medical Centre
 2/3 Rodeo Rd,
 GREGORY HILLS, N.S.W., 2557
 Ph: Fax:
 Secure Email:

Date:

Dear Dr :

Patient full name (print)	Address	DOB

Other family members (if under 18 years of age)	Address	DOB

The above mentioned now attends this practice. To assist in their future medical management. Would you kindly forward: (tick option)

Please do not send original documents

Their clinical records

An accurate health summary, with relevant correspondence and results,

Details of any CDM or PIP Items claimed within the last 2 years. (eg GPMP)

These records can be forwarded by: (tick option)	<input type="checkbox"/> Mail <input type="checkbox"/> Fax <input type="checkbox"/> Encrypted email (PKI) <input type="checkbox"/> Non rewritable CD.
Or electronic version format should be: (tick option)	<input type="checkbox"/> HTML <input type="checkbox"/> XML

Patient Signature-----

Doctor