Elanora Heights medical practice

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REQUEST for TRANSFER of MEDICAL RECORDS

THIS REQUEST REFERS TO: Medical Records *or* Summary of Medical Records

I, (*insert full name*)

_____

_____

of (*insert full address*)

_____

_____

Date of Birth: _____/_____/_____

Request to have my files transferred **from** the following doctor:

Doctor:

_____

Medical Centre:

_____

Address:

_____

_____

Signature: **Date**: / /

Why do you wish to transfer your files?

_____

_____

Please include other family members in the transfer:

Full name _____DOB_____/_____/_____Signature_____

Full name _____DOB_____/_____/_____Signature_____

Full name _____DOB_____/_____/_____Signature_____

Full name _____DOB_____/_____/_____Signature_____

Parent must sign if patient is under 16 years of age

Office use:

Copy of ID for each person attached? *Files photocopied?* *Registered post #:*

Date posted: *Name and signature:*