



PATIENT TRANSFER FORM

AUTHORITY TO RELEASE INFORMATION

Please complete a separate form for each individual patient

DEAR DR: _____

ADDRESS: _____

PHONE: _____

FAX: _____

THE FOLLOWING PATIENT HAS DECIDED TO ATTEND THIS PRACTICE ON A REGULAR BASIS AND WILL BE CARED FOR BY DR _____

NAME _____

DOB _____

ADDRESS _____

- Health Summary Only
- Complete Medical Record
- Other: (please specify) _____

Where possible please provide file in XML format on disc or USB.

Please note: If using Best Practice XML is not an acceptable format for our system please send hard copy of file.

PATIENTS AUTHORITY

I hereby give permission to release all requested information to the above mentioned doctor/ practice.

PATIENT SIGNATURE: _____

DATE: _____

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