Centre Health Medical Centre

398 PRINCES HIGHWAY
WOONONA NSW 2517
PH: 4283 9000 **FAX**: 4285 7632

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:** _____