# REQUEST FOR MEDICAL RECORDS TRANSFER

**Centre Health Medical Centre Campbelltown**
**Level 1, 242 -248 Queen Street, Campbelltown NSW 2560**
**Ph: (02) 4629 0555**
**Fax: (02) 4629 0599**

**Practice Name:** _____

**Practice Address:** _____

**Phone No.** _____

**Fax No.** _____

Dear Doctor,

**Re: Request for transfer of patient medical records**

As the patient listed below now attends this practice, please forward a copy of their medical records (or a complete and accurate health summary) and any other relevant clinical information to assist in the continued management of their healthcare.

**Patient (full name):** _____

**Address:** _____

**Date of Birth:** _____

**If sending the records electronically, please send them in an .xml format.**

- ☐ Health Summary Only
- ☐ Complete Medical Record
- ☐ Other: _____

## Patient consent

I, _____ consent to the release of my medical records and any other relevant clinical information to **Centre Health Medical Centre Campbelltown.**

Patient name: (please print) _____

Signature: _____ Date: _____

If not patient signing – name: (please print) _____

Your relationship to patient: (e.g. Mother, Father, guardian, carer)_____