REQUEST FOR MEDICAL RECORDS TRANSFER

Centre Health Medical Centre Unanderra
Shop 11, 102 Princes Highway, Unanderra NSW 2526
Ph: (02) 4271 5115
Fax: (02) 4272 2258

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: _____

<u>If sending the records electronically, please send them in an .xml format.</u>

- ☐ 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 Unanderra.**

Patient name: (please print) _____

Signature: _____ Date: _____

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

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