DATE……

Name of Previous Clinic……

Details of Previous Clinic……

……

P:……**F:**……

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, this practice uses Best Practice.

Patient consent

I, _____consent to the release of my medical records and any other relevant clinical information to Hamilton Family Practice.

Patient name: (please print) _____

Signature: _____Date:_____

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

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

Yours sincerely,

Hamilton Family Practice
130 Lonsdale Street, Hamilton, Vic, 3300
P: (03) 5572 5592 F: (03) 5572 5348 E: reception@hamiltonfamilypractice.com.au