

Request for Medical Records Transfer



Sandy Hill Medical Centre

Dear Dr/Practice:	
Phone:	
Fax:	

Patient Name:	
Address:	
Date of Birth:	

Other family members (under the age of 18):

FULL NAME:	DOB:	GENDER (Male/Female/ Other)

<input type="checkbox"/> An accurate health summary, with relevant correspondence and results,	<input type="checkbox"/> Details of any CDM or PIP Items claimed within the last 2 years. (eg GPMP)	<input type="checkbox"/> Other relevant Information
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The above patient now attends this practice. To assist in their future medical management, would you kindly forward their relevant clinical records. These can be forwarded **electronically, by mail, or preferably by fax**. Electronic version format should be **XML**.

Patient consent: I ,, hereby request and authorise you to release my health information to Sandy Hill Medical Centre, Sandringham.

Signed: **Date:**