



Level 1, 1571 Ferntree Gully Road, Knoxfield VIC 3180

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REQUEST FOR MEDICAL RECORDS TRANSFER

Dear Doctor: _____

Clinic Name: _____

Address: _____

Phone: _____ Fax: _____

Email: _____

Patient Name: _____ DOB: _____

Other family members transferring medical information (if under 16):

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

I hereby consent to the release of my/our medical information to:

Dr _____ at Together Medical Family Practice

Signature: _____ Date: _____

The above-named patient(s) is now attending this practice. Please kindly forward an accurate health summary and full medical records in XML format (we use Best Practice) to our clinic at your earliest convenience. For medicolegal reasons do not send original records. Thank you.

Please also advise the date last billed for the following items if applicable:

75+ Health Assessment (707)		Care Plan (965)/Care Plan Review (967)	
45-49 Health Assessment (707)		Mental Health Care Plan	
Heart Health Assessment (699)			

FOR OFFICE USE ONLY

Initials: _____ Date: _____

(on behalf of Together Medical Family Practice)