NORTH
ROAD
MEDICAL

409 North Road
CAULFIELD SOUTH VIC 3162
T. 03 9576 9311
F. 03 9578 1682
NORTHROADMEDICAL.COM.AU
RECEPTION@NORTHROADMEDICAL.COM.AU
ABN 22 428 067 827

Request for Medical Records Transfer

Date: _____

Dear Doctor,

RE: _____

_____

_____

Date of Birth: _____

The above named patient is now residing in this area and wishes to attend our Clinic.
He/she has requested that a copy of their medical file, including specialist reports and relevant radiology and pathology reports be forwarded to this clinic.

This information can be forwarded by fax, mail or electronically.
We use Best Practice clinical software and prefer records to be sent electronically via .XML format.

If you use another software program please send the medical history as a PDF format or paper file.

Other members of the family whose record requires to be transferred:

Patient Name	Date of Birth
_____	_____
_____	_____
_____	_____

Please find below an authority signed by the patient, giving consent for this information to be supplied by you.

PERMISSION TO OBTAIN MEDICAL RECORDS

I hereby give permission for the North Road Medical Centre to obtain my medical records from your practice.

Signed: _____

Date: _____

Thank you for your co-operation in this matter.

Previous Practice Details (Outgoing):

Practice Name: _____

Practice Address: _____

_____

Practice Phone number: _____

Practice Fax number: _____