|  |  |  |
| --- | --- | --- |
| Date: |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| To: |  | Fax no: |  |

|  |  |
| --- | --- |
| Home/Postal Address: |  |

|  |  |
| --- | --- |
| Email Address: |  |

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.

If sending the records electronically, please send an **HTML or PDF** format, otherwise **PAPER COPY**.

Patient consent

|  |  |  |
| --- | --- | --- |
| I,  |  | consent to the release of my medical records and any other |

relevant clinical information to **Bluff Road Medical Centre**.

|  |  |
| --- | --- |
| Patient name: (please print) |  |

|  |  |
| --- | --- |
| **Address:** |  |

|  |  |
| --- | --- |
| **Date of Birth:** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Signature: |  | Date: |  |

Please include other members of my family (18 years and under) as listed:

|  |  |  |  |
| --- | --- | --- | --- |
| Re: |  | D.O.B |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Re: |  | D.O.B |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Re: |  | D.O.B |  |

Yours sincerely,

|  |
| --- |
|  |