



REQUEST FOR TRANSFER OF PATIENT MEDICAL RECORDS

To/Surgery Name and Suburb: _____

Phone/Fax Number (if known): _____

Dear Doctor/Practice Manager, the patient listed below is now attending Health Plus General Practice.

Please kindly forward a copy of:

- Complete and accurate health summary
- Full Medical Records

As well as any other relevant clinical information to assist in the continued management of their healthcare

Patient Name: _____

Date of Birth: _____

Address: _____

Phone: _____

Patient Consent:

I, _____ consent to the release of my medical records and any other relevant clinical information to Health Plus General 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, on behalf of the Practice Manager

Health Plus General Practice U39-40, 68 Dalkin Crescent, Casey, ACT 2913

Tel: (02) 6109 9320 Fax: (02) 6109 9329

Email: contact@healthplusgp.com.au

Note to **PATIENTS**: Practices may charge a fee for the transfer of medical records. Health Plus General Practice is unfortunately unable to pay any fees associated with medical records transfer, payment of these fees is the responsibility of the patient.

Note to **PRACTICES**: We accept hard copy of records OR **electronic records in XML format only**. This is due to our software compatibility. Thank you for your understanding.