Warragul
FAMILY MEDICINE

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www.WarragulFamilyMedicine.com.au

Request for Medical Records Transfer

/ /

(Dr) _____

(Clinic) _____

(Address) _____

_____

(Fax/Email) _____

Dear Dr _____

Patient Full Name	Address	DOB

Other Family Members (if under 18 years of age.)	Address if not as above	DOB

The patient/s mentioned above now attend/s Warragul Family Medicine. To fully assist with their future medical management, would you kindly forward a completed copy of their Medical History to as at your earliest convenience.

- ☐ Their clinical records
- ☐ An accurate health summary, with relevant correspondence and results,
- ☐ Details of any CDM or PIP Items claimed within the last 2 years. (eg GPMP)

Please do not send original documents

These records can be forwarded by mail or fax.

Electronic version format to be **XML only**

Yours sincerely

Doctor …… {Name of GP}

PATIENT'S SIGNED AUTHORITY

I …….. {Patients full name}

authorize the release of my/my families' medical records to be forwarded to Warragul Family Medicine, 77 Victoria Street, Warragul.

Signed: …… Date: ……