77 Victoria St, Warragul. Vic 3820
PO Box 1164
P: (03) 5622 2973 F: (03) 5622 2933
www.warragulfamilymedicine.com.au
reception1@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 at your earliest convenience.

- ☐ Their clinical records
- ☐ An accurate health summary, with relevant correspondence and results
- ☐ Most recent 721, 723, 732, 2715,2712

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: ………………