Dr Sanjeev Rana
Dr Jeffrin George
Dr Zairish Omer
Dr Mohsin Shahzad
Dr Michael Dawber

Request for Transfer of Medical Records

Date: …./…./……..

To: ……….
(Medical practice name)

……….
(Medical practice address)

Dr. ……………………………………………………………………………. *(Dr's Name)* Ph: ……………………………………

Fax: …………………………………..

We wish to advise you that the following patient(s) are now attending this medical practice and would like to have his/her/ their medicals records transferred. We would appreciate it if you could send any relevant information which would assist with their continuing care.

If your practice uses a Medical software we would appreciate if you could export the patient files onto disc using XML format. Thank you.

We/ I hereby authorise the release of my/ our medical records to Two Rocks Medical Centre.

Name: ……………………………………………………………… DOB: …./…./…….. Patient's Signature: ……………………

Name: ……………………………………………………………… DOB: …./…./…….. Patient's Signature: ……………………

Name: ……………………………………………………………… DOB: …./…./…….. Patient's Signature: ……………………

Address: ………

Please include other members of my family (16 years and under) as listed:

Name: ……………………………………………………………………………… DOB: …./…./……..

Name: ……………………………………………………………………………… DOB: …./…./……..

Name: ……………………………………………………………………………… DOB: …./…./……..

Thank you
Two Rocks Medical Centre

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