Dr Sharon Vasey
Dr Craig Gordon
Dr Chinniah Prabhakar
Dr Sheela Prabhakar
Dr Suzanne Edlinger

Request for Transfer of Medical Records

Date: …./…./……..

To: ……..
(Medical practice name)

……..
(Medical practice address)

Dr. …….. *(Dr's Name)* Ph: ……..

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 Practice.

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,