Date:

Doctor: _____ **Phone:**_____
Practice Address: _____ **Fax:** _____
_____

Dear Doctor,

Re: Request for transfer of patient medical records

As the patient listed below now attends this practice, please forward a copy of their medical records (or a complete and accurate health summary) and any other relevant clinical information to assist in the continued management of their healthcare.

Patient (full name): _____

Address: _____

Date of Birth: _____

If sending the records electronically, please send them in an **.xml** format.

Patient consent

I, _____ consent to the release of my medical records and any other relevant clinical information to **<insert name of 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,

Newport Doctor
354 Barrenjoey Road
Newport NSW 2106
99974441
enquiries@newportdoctor.com.au