Request for Medical Records Transfer

CLIFTON MEDICAL PRACTICE
20 Norman St
Clifton QLD 4361
Ph: 07 46973 097 Fax 07 46123 187

Previous Medical Practice:_____

Previous Medical Practice ph: _____ Fax:_____

Patient Full Name	Address	DOB

Other Family Members (if under 18 years of age.)	Address	DOB

The above mentioned now attends this practice. To assist in their future medical management, would you kindly forward (tick option):
Please do not send original documents.

- ☐ Their clinical records
- ☐ An up-to-date health summary, with relevant correspondence and results.

These records can be forwarded by Medical Objects, fax, mail or usb.

Clifton Medical Practice.

PATIENT'S SIGNED AUTHORITY

I …….. {Patients full name}

Of …….
{Patients current address and date of birth}

Formerly of …….
{Patients former address if applicable}

Authorise the release of my/my families' medical records to be forwarded to Clifton Medical Practice.

Signed: …… Date: ……