# REQUEST FOR TRANSFER OF MEDICAL RECORDS

To Whom It May Concern at: _____

_____

The following patient attends this medical centre and would like to transfer their records to our practice. Please arrange for the transfer of medical records as authorised below:

Patient: _____

Date of Birth: ___ /___ /_____ Phone: _____

Other Family to Transfer: Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

I authorise my records to be transferred to:

Health Yeppoon
2/11 Hill Street
Yeppoon, 4703
Ph: 07 4939 3041
admin@healthyeppoon.com.au

☐ Health summary
☐ Other: _____

_____

Signed _____ (Patient / Guardian) Date: ___/___/_____

Please send via Medical Objects or via email to:

- ☐ Dr Kaitlyn Mullane
- ☐ Dr Kristel Kemmerling
- ☐ Dr Amanda Tait

*Please note we are a paper free practice. We are not able to accept CD's.*

Please check if there are any recalls due for this patient and inform us of these in writing if you wish us to take over the responsibility of these, otherwise we will leave the medico-legal responsibilities of these to your practice.

If the patient has had a GP Management Plan, Team Care Arrangement, or Mental Health Care Plan completed, please send the most recent of these documents.

Thank you for your assistance in the ongoing care of this patient.