Breed Street Clinic

37 Breed Street, Traralgon
PH: 5176 1933 Fax: 5174 6165

REQUEST FOR TRANSFER OF RECORDS

Date: ____/_____/_____

The following patient/s are currently attending this clinic, and have requested that you forward a copy of their full medical records, at your earliest convenience.

PATIENT NAME	**Patient 1.**	**Patient 2.**
ADDRESS		
DATE OF BIRTH		

Would you please indicate if any CARE PLANS have been prepared – especially a 2702, 2710, or such items as: 700, 713, 717, 721, 723, 725, 900.

We currently use Best Practice – please use "XML" format as this is compatible with our system

We appreciate your assistance and enclose a signed authority below.

Authority to release medical records:

I hereby authorise Dr _____ _____

Of:_____Clinic

Address_____

To release my/our medical information to Dr _____

Signed:

Patient 1 Patient 2:_____