Request for Transfer of Patient Complete Medical Records

Previous Doctors Name: _____

Previous Practice Name: _____

Practice Address: _____

Suburb & Postcode: _____

Contact Number: _____ **Fax Number:** _____

Email: _____

As the patient listed below now attends this practice, please forward a copy of their <u>Complete Medical Record</u> including the following ticked below to assist in the continued management of their healthcare

☐ Patient Current Medications	☐ Pathology Results	☐ Radiology Reports
☐ All Correspondence In & Out	☐ EPC, TCA, MHCP's	☐ Health Assessments
☐ Immunisations	☐ Specialist Letters	☐ Other – Please Specifiy

I, _____ _____

(Patient Given & Surname) ***(Date of Birth)***

_____

(Address)

_____ _____

(Suburb) ***(Postcode)***

consent to the release of my complete medical records and any other relevant clinical information in

<u>.XML format,</u> Posted, Faxed or Emailed to the practice manager at:

Pascoe Vale Road Medical Centre
Shop 4/1540 Pascoe Vale Road, Coolaroo VIC 3048
Phone: 03 9344 1304 Fax: 03 9344 1305
Email: practicemanager@pvrmc.com.au

Patients Name: *(please print)* _____

Patients Signature: _____

Parent / Guardian Signature: _____

Relationship to Patient: _____

<u>Disclaimer:</u> The content of this fax/Email and any attachments may be private and confidential, intended recipient of this message you must not read, copy, disclose, use or store in any way the information in this fax/Email. If you are not the intended recipient, please notify us immediately and discard this document and any attachments. Our organization respects the privacy of individuals.

_____

Office Use Only:
Faxed by: _____ **Date:** _____ **Scan to Pt File:** Yes / No **Blk Folder:** Yes / No
Contact 1: _____ **Contact 2:** _____ **Contact 3:** _____
Spoke to: _____ **Spoke to:** _____ **Spoke to:** _____