Request for Medical Records Transfer

NEW STREET MEDICAL CENTRE

Medical Records to be transferred from:

Doctor:

Clinic Name:

Address:

Patient:

Name:

Date of Birth:

Address:

This patient is now attending our centre and has requested their medical records be transferred.
Our clinic uses Medical Director 3. Please send medical records on a disc in the MD3 XML format. Please **DO NOT SEND** Best Practice xml format or HTML format.

If you use another program, please send an electronic copy of the medical records in PDF format or a Patient Health Summary.

In particular, we ask that you send the following information:

- Patient Health summary
- Recent specialist letters
- Name of past pathology company tests have been processed by
- Recent x-rays

Please also include histories of the following family members:

Name: *DOB:*

Name: *DOB:*

Name: *DOB:*

Thank you for your assistance.

NEW STREET MEDICAL CENTRE

PATIENT DECLARATION

I authorise the release of my medical records.
(Full Name)

Please send to at the above address.
(Receiving Doctor/Clinic name)

Signed: Date: