Request and Consent - Transfer of Medical Records

Att: Dr_____

_____

Phone: _____

Fax: _____

Dear Doctor,

The Patient(s) listed below now attend this practice and as requested that his/her complete health record via **Medical Objects**, to assist with their ongoing care.

Please Include:

Specific Health Concern(s): _____

Reports: _____

Pathology/Imaging: _____

Clinical Reminders & Due Dates: _____

Item Number	Date Billed	Item Number	Date Billed	Item Number	Date Billed
721/723		2700		2715	
732		2701		2717	

Requesting Dr:

Dr Peter Alroe Dr Richard McDermott Dr Denise Z McDonald Dr Sarah Burgess Dr Kylie Hodge

~~~ Please forward at your earliest convenience via **Medical Objects** or fax (07) 5448 9300) ~~~

~~~ PLEASE DO NOT SEND CD ~~~

PATIENT CONSENT:

I/We give permission for my/our medical records to be transferred to North Shore Medical Centre as this is the practice I am/we are now attending for medical care.

Patient Name: _____ DOB: _____ Minor: YES / NO

Signature: _____ Parent/Guardian: _____

Patient Name: _____ DOB: _____ Minor: YES / NO

Signature: _____ Parent/Guardian: _____

Patient Name: _____ DOB: _____ Minor: YES / NO

Signature: _____ Parent/Guardian: _____

Patient Name: _____ DOB: _____ Minor: YES / NO

Signature: _____ Parent/Guardian: _____

NORTH SHORE MEDICAL CENTRE (ABN 41906254950)

PO Box 9547 Pacific Paradise Q 4564

Phone: 07 5448 9200 Fax: 07 5448 9300
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