

## Transfer of Records Form

Existing Medical Practice Name: \_\_\_\_\_

Existing General Practitioner: \_\_\_\_\_

Your Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Post Code: \_\_\_\_\_ State: \_\_\_\_\_

I request that you forward details of my health records to North Medical. I authorise the doctor/practice named above to release my historic health records.

Please advise me in writing if administrative costs apply and is so provide a scale of fees.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Dear Doctor,

### **Re: Patient Request for Access/Release of Personal Health Information**

The patient listed above requests that their entire medical treatment records are forwarded to North Medical for their ongoing care. Please ensure the following is included:

- Copy of last GPCCMP (or last billed date at a minimum)
- Copy of last Health Assessment (or last billed date at a minimum)

Where possible please supply a full medical history as a Best Practice (.xml file) to enable us to provide efficient and effective ongoing patient care.

Please send records to via secure means to:

- Email: [info@northmed.com.au](mailto:info@northmed.com.au)
- Fax: 9022 7878

Regards,

North Medical Management