NORTH MEDICAL

Transfer of Records Form

Existing Medical Practice Name: ____

Your Name: ________________________________ DOB: _______________________

Address: ____

Post Code: __________ State: _______

I request that you forward details of my health records to the doctor mentioned above, who is now responsible for my ongoing care. I authorise the doctor/practice named above to receive 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
- Fax: 9022 7878

Regards,

North Medical Management

702 Norman Street
Invermay Park, Vic, 3350
P 4344 4044 | f 9022 7878
www.northmed.com.au