KINGSCLIFF BEACH MEDICAL

40 Marine Parade, Kingscliff, NSW, 2487
Telephone: 02 6674 3266 Fax: 02 6674 3300

Dr Zoe Burgman **Dr Adrian Smith** **Dr Bronwyn Mann**
Dr Victor Shawpan **Dr Dennis Rhodes** **Dr Yasmin Trinidad**
Dr Loretta Weir

TRANSFER OF MEDICAL HISTORY REQUEST

Date: ……/……./…….

Patient Name: …… **DOB:** ……/……./……..……

Current Address: ……..……..

Previous Address: ……..……..

Telephone Number/s: ……..……..

Attention:*(Doctor)* ……..……..

(Doctor's Address) ……..……..

……..……

Telephone No: …… **Fax No**: ……..……

Other Family Members:

Name: ……..….**Signature**……..……**DOB:**……../……../……

Name: ……..….**Signature**……..……**DOB:**……../……../……

Name: ……..….**Signature**……..……**DOB:**……../……../……

The above patient/s, whose signature appears below, has requested that this practice continue management and the management of the family members listed. In order to ensure continuity of care, we would appreciate a copy of the following.

☐ **Health Summary**

☐ **Specialist Letters**

☐ **Pertinent Investigations**

☐ **GP and or TCA and or Mental Health Plan**

As mailed paper file <u>OR</u> computer file on disc in XML format.

☐ **Patient has requested the complete medical record.**

As mailed paper file <u>OR</u> computer file on disc in XML format.

If you do charge a fee for files to be transferred, please invoice the patient at their current provided address.

Thank you for your assistance with the ongoing care of this patient.

I give authority for a copy of my medical history, and the medical history of the listed family members, to be released to Kingscliff Beach Medical in the format described above.

Signed: …… Date: ……/……/…….