Request for Medical Records Transfer

Kearns Medical Centre
Shop 6, 70 Kearns Avenue
KEARNS, NSW 2558
Ph: (02) 4604 6071
Fax: (02) 4604 6072
Email: info@kearnsmedical.com.au

Date: _____

Dear Dr/Surgery Name: _____

Ph: _____ **Fax:** _____

Email:_____

Patient full name (print)	**Address**	**DOB**
		DD/MM/YY

Other family members (if under 18 years of age)	**Address**	**DOB**
		DD/MM/YY
		DD/MM/YY
		DD/MM/YY

The above mentioned now attends this practice. To assist in their future medical management. Would you kindly forward:

- ☒ Please send clinical documents
- ☒ Their clinical records
- ☒ An accurate health summary, with relevant correspondence and results,
- ☒ Any other related information on the file

These records can be forwarded by:	☒ Mail ☒ Fax / Email

☐ **Copy of Patient ID / Parent or Guardian ID & Patient Medicare Attached**

Yours sincerely,

Kearns Medical Centre

Patient Signature:_____

Complete only if applicable - If patient is Under the age of 18 both parents must sign:

Parent Signature 1 : _____

Parent Signature 2: _____