GARDENS MEDICAL GROUP

LEVEL 3, 470 WODONGA PLACE
ALBURY NSW 2640
PH: 02 6021 3555
FAX: 02 6058 6168
E: gmg@thegardensmedical.com.au

Date: ______________________________

Practice Name: ____

Practice Address: ____

Practice Phone: ____

Practice Fax: ____

Practice Email: ____

Dear Doctor,

Re: Request for transfer of patient medical records

As the patient listed below now attends this practice, please forward a copy of their medical records (or a complete and accurate health summary) and any other relevant clinical information to assist in the continued management of their healthcare.

Patient (full name): ____

Address: ____

Date of Birth: ____

If sending the records electronically, please send them in an **.xml** format.

Patient consent

I, ___________________________consent to the release of my medical records and any other relevant clinical information to Gardens Medical Group.

Patient name: (please print) ____

Signature: ____ Date:______________________________

If not patient signing – name: (please print) ____

Your relationship to patient: (e.g. Mother, Father, guardian, carer) ___________________________________

Yours sincerely,

Signature: ____

Name: ____

Gardens Medical Group.