Healesville
MEDICAL CENTRE
Est. 1980

34 Symons Street, Healesville VIC 3777
Ph: (03) 5962 4379 Fax: (03) 5962 4674
admin@healesvillemedicalcentre.com

Date .....

Clinic Name .....
Address .....
Phone Number ..... Fax .....
Email .....

Dear Doctor,

Re :
D.O.B :
Address : , ,

The above patient/s is/are now attending this clinic. Would you kindly forward a copy of their medical record to our clinic, with information that would greatly help us to provide adequate, ongoing care for the patient.

If you are a 'paperless' clinic we would appreciate the history being forwarded on Disc :
XML rather than hard copy. **We will also accept records by Email as a XML attachment.**

Please advise the patient if there is any processing fee and the fee is to be billed directly to the patient.

Yours sincerely

for
Healesville Medical Centre

Patient declaration:

I hereby give permission for the Healesville Medical Centre to obtain my medical records from your clinic.

Signed.....

Could you also include other family members as listed below:**

Name……D.O.B…….....Sign.....

Name……D.O.B…….....Sign.....

Name……D.O.B…….....Sign.....

****Due to State & Federal Privacy laws, children 16 years and over must sign for their own records.**