110 - 112 Railway Ave.
RINGWOOD EAST VIC 3135
eastringwoodclinic.com.au
T: (03) 9870 4455 F: (03) 9870 1379
Encrypted email:588828@argus.net.au

Date:__/__/__

To: _____ Fax No. _____

_____ Phone No. _____

Dear Doctor,

Request for transfer of patient medical records

The patient listed below now attends this practice, please forward a copy of their medical records.

Please send the records electronically in html format. If using Medical Director send in .xml format.

Patient (full name): _____

Date of Birth: _____

Address: _____

_____

Additional family members:

Name:_____ Date of Birth:_____

Name:_____ Date of Birth:_____

Name:_____ Date of Birth:_____

Name:_____ Date of Birth:_____

Patient consent

I, _____ consent to the release of my medical records and any other relevant clinical information to **East Ringwood Clinic.** In accordance with Australian Privacy Principle 12, we accept that our practice must, on request by an individual, give the individual access to their personal information, unless an exemption applies. For further information, refer to the Office of the Australian Information Commissioner website: www.oaic.gov.au

Patient name: (please print) _____

Signature: _____ Date:_____

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

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

Please email the completed form to: reception@eastringwoodclinic.com.au