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 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](http://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