Transfer of Medical Records Consent Form

I_________________________________ give consent for my medical records to be released to:

Family Health Clinic Malvern
76 Glenferrie Road, Malvern 3144
Tel: (03) 7033 0288 Fax: (03) 7033 0289 E-mail: reception@familyhealthclinics.com.au

Patient D.O.B: __ / __ / __ Medicare Number: ______________________________

Address of Patient: ____

Contact Details: Mobile: __________________________ E-mail: __________________________

Patient's previous clinic/GP: ____

Phone: ( ) ______________________________ Fax: ( ) __________________________

Patient signature: ___________________________________ Date: ___ / ___ / _____

Electronic Record in **XML** to please including:

- ☐ Allergies & adverse reactions
- ☐ Health Assessment /
- ☐ Health Summary
- ☐ Investigation Reports
- ☐ Immunisation History
- ☐ GP Care Plan (721)
- ☐ Visit Notes
- ☐ Team Care Arrangement (723)
- ☐ Specialist Letters
- ☐ All Existing Records

I authorise for this release to be;

- ☐ Securely Faxed / emailed to the requesting practice
- ☐ Sent by mail to the requesting practice (If sending by CD, format must be in **XML.**)

Office Use Only:

Date Received: ___ / ___ / _____ Date Records Sent: ___ / ___ / _____

Sent by: [] Mail [] Fax [] E-mail

Name of Person completing release: ____