REQUEST FOR TRANSFER OF MEDICAL RECORD/S

To Total Health Care practitioner name:
____

I, ____,

DOB: ______/_______/____________

Medicare card number: ______________________

Reference on card: ___________ Expiry date: _______/_______________

give informed consent for a copy of my medical record/s to be provided to

_________________ (new practitioner name for copy of records)

_________________ (telephone number of new practitioner)

____ (physical address and practice name for new practitioner)

Yours faithfully,
____

Dated   _______/_______/_______________
(patient signature if 18 years or older/guardian signature)

____
(print name of person signing above)