PYMBLE FAMILY DOCTORS
DEDICATED TO YOUR HEALTH AND WELL BEING

To Whom It May Concern

REQUEST FOR TRANSFER OF MEDICAL RECORDS

Please arrange for the transfer of medical records as authorised below.

Patient: Mr ☐ Master ☐ Mrs ☐ Ms ☐ Miss ☐ Other ______________________________

First Name ________________________________ Middle Name ______________________________

Last Name ____ Male ☐ Female ☐

Home Address ____

____ State ______________ Postcode___________

Date of Birth ___ /___ /_____ Contact telephone number ______________________________

Patient Authorisation:

I hereby authorise ____ (Medical Practice)

Phone: _________________________________

Fax: ___________________________________

To release copies of my medical records to:

Pymble Family Doctors
99-101 Grandview Street
Pymble NSW 2073
Ph: (02) 9144 6208 Fax: (02) 9144 6209
****Note: We use Best Practice. If possible, please send via BP .xml format ****

____
Patient / Guardian Signature

Date: ___ /___/_____