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 ___ /___ /19___ Contact telephone number _____

Patient Authorisation:

I hereby authorise Dr/Practice name _____

Address _____

_____ State _____ Postcode_____

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, please send via BP .xml format, via CD or USB if possible****

Signed

_____
Patient / Guardian Signature

Date ___/___/_____