PFD
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 **Pymble Family Doctors Ph: (02) 9144 6208 Fax: (02) 9144 6209** to release copies of my medical records to:

Dr _____________________________

Medical Practice/Centre: ___________________________

Address: _____________________________ State ________ Postcode ________

Phone: _________________________

Fax: _________________________

____
Patient / Guardian Signature

Date: ___/___/______