Tweed Coast Medical

REQUEST FOR TRANSFER OF MEDICAL RECORDS

Date: _____

To_____(Doctor/Practice Name

Ph: _____Fax: _____

I,_____Date of Birth: _____
Hereby authorise the transfer of copies of my past medical history which are relevant to ongoing health conditions, in particular;

□ Patient Health Summary, including all relevant reports, or

□ Complete health record (Please send file in XML, we do not accept file in CDs)

This request is also made on behalf of my dependants as named below:

_____ Date of Birth: _____

_____ _____Date of Birth: _____

_____ Date of Birth: _____

PREFERRED METHOD TO RECEIVE MEDICAL RECORDS
VIA MEDICAL OBJECTS or XML file on
CD We use Best Practice software

□ Dr Robert Kearney □ Dr Amany Galil □ Dr

Signature of patient _____ Date: _____

Address: Suite 5/51 Tweed Coast Road, Cabarita Beach NSW 2488
Ph: 02 6676 0106
Fax: 02 6676 0059
Email: admin@tweedcoastmedical.com.au