



## Transfer of Medical Records between Doctors

Date: \_\_\_\_\_

**Dear Dr** \_\_\_\_\_

**At** \_\_\_\_\_

**Phone No.** \_\_\_\_\_

**Fax No.** \_\_\_\_\_

The below patients are now attending this practice. He/she has made an unsolicited request for their medical records. Could you please forward a copy of their medical history, including relevant reports and letters. We use **Best Practice software**, and would prefer to receive the file in **XML format on a CD or USB**. Please contact our Reception Manager, Debra Peacock, or Best Practice staff if you require information on how to complete this. **If your practice charges a fee to patients for transferring medical records, please send a health summary in the interim via fax or email.**

Thank you for maintaining continuity of this/these patient/s medical care.

**Per:** \_\_\_\_\_

**The Reception Team, Cremorne Medical Practice**

### **Patient's Consent:**

I hereby authorise Cremorne Medical Practice to request the transfer of my personal medical records on my behalf.

**Patient's Name:**

**Date of Birth:**

**Signature (if 16 years old and over):**

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