

Request to Transfer Medical Records

Date:

Name of Previous Practice:

Phone Number:

Fax Number:

Email Address:

Patient Full Name:

Date of Birth:

Address:

Dear Doctor,

Re: Request for transfer of patient medical records

As the above patient now attends this practice, please forward a copy of their medical records (or a complete and accurate health summary) and any other relevant clinical information to assist in the continued management of their healthcare.

Our preferred method of receiving files is in **.xml** format and/or via healthlink EDI - **warwmcsc**

PATIENT DECLARATION: I consent to the release of my medical records and any other relevant clinical information to Warwick Medical Centre and Skin Clinic.

Patient name: _____

Signature: _____ Date: _____

Parent/Guardian Name (if under 16): (please print) _____

Your relationship to patient: (e.g. Mother, Father, guardian, carer) _____

Yours sincerely,

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Healthlink: warwmcsc