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TRANSFER OF PATIENT RECORDS

Dear Dr. _____ of _____

_____

Phone: _____

Fax: _____

The person or persons below are attending our practice now. We would appreciate it very much if you could forward us a complete medical record for continuity of care.

IT IS PREFERRED IF YOU CAN SEND US THE INFORMATION IN A DISC IN XML FORMAT.

Patient Name: _____ DOB:_____

Patient Name: _____ DOB:_____

Patient Name: _____ DOB:_____

Patient Name: _____ DOB:_____

Patient Address:_____

_____

Patient Authority: I authorise the release of the above medical record/s to doctors at Dale Medical Centre.

Patient/ Parent/Guardian Signature: _____

Attending Doctors Signature: _____