gladstonestreet
MEDICAL CLINIC

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Request for Medical Records Transfer

Date / /

(Dr) ___________________________________

(Clinic) ___________________________________

(Address) ___________________________________

____

(Fax/Email) ___________________________________

Dear Dr

Patient Full Name	Address	DOB
	Telephone Number:	

Other Family Members (if under 18 years of age.)	Address if not as above	DOB

The above mentioned now attends this practice. To assist in their future medical management. Would you kindly forward

- ☐ The patient's/patients' clinical records
- ☐ An accurate health summary, with relevant correspondence and results,
- ☐ Details of any CDM or PIP Items claimed within the last 2 years. (eg GPMP)

Please do not send original documents. These records can be forwarded by mail, fax, encrypted email (PKI), Non rewritable CD. Electronic version format should be (tick option) ☐ HTML ☐ XML

If payment is required for the transfer of records, communicate this directly to the patient via the address/number above. Gladstone Street Medical Clinic accepts no responsibility for any fees incurred in this process.

Yours Sincerely

Doctor ………………………………………………………… {Name of GP}

PATIENT'S SIGNED AUTHORITY

I ………………………………………………………… {Patients full name} authorise the release of my/my families' medical records to be forwarded to Gladstone Street Medical Clinic. I understand I am responsible for any fees that may be charged by my previous providers for the transfer of records.

Signed: …………………………………… Date: ………………