TRANSFER OF MEDICAL HISTORY REQUEST

MAIN STREET
MEDICAL CENTRE

PREVIOUS SURGERY DETAILS

Attention:*(Doctor)* _____

(Doctor's Address) _____

_____

Phone No: _____ **Fax No**: _____

PATIENT DETAILS

Patient Name: _____ **DOB:** ___/___/___

Current Address: _____

Previous Address: _____

Phone No: _____

The above patient is now attending our surgery. In order to continue their care it would be appreciated if you would forward a copy of relevant medical information listed below as soon as possible;

- □ **Health Summary only**
- □ **Complete medical record**

Main Street Medical Centre is a paperless practice, using Best Practice software. Please send records electronically on disc in XML format, OR send via Medical Objects;
attention Dr _____

If you charge a fee for files to be transferred, please invoice the patient at their current provided address.

Thank you for your assistance with the ongoing care of this patient.

I give authority for a copy of my medical history, to be released to Dr _____

at Main Street Medical Centre in the format described above.

Signed: _____ Date: ___/___/___

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