MIDDLE ISLAND
MEDICAL CLINIC

Request for transfer of Medical Records

Please complete this form if you would like a copy of your health records sent to Middle Island Medical Clinic from a previous health professional or organisation.

Patient's Details

Name			
Date of Birth		Phone No.	
Current Address			
Previous Address			

Details of your children aged under 16 years (if their records are also being requested)

Name		Date of Birth	
Name		Date of Birth	
Name		Date of Birth	

Details of the previous Clinic / Doctor

Doctor Name	
Clinic Name	
Clinic Address	
Clinic Phone No.	

Please send a copy of the following documents:

- ☐ Complete Medical Record
- ☐ Specific information, relevant investigations and treatments

  Details _____

PATIENT AUTHORITY,

I hereby authorise the above request for the transfer of my medical records (and/or my child, if applicable) to Middle Island Medical Clinic for my/our future medical care.

Print name of person completing this form _____

Signature _____ **Date** _ _ / _ _ / _ _ _ _

(NOTE: YOU CANNOT SIGN FOR YOUR SPOUSE OR ADULT CHILDREN)

OFFICE USE ONLY (TO BE COMPLETED BY PREVIOUS CLINIC)

Please advise of recent Billing or Current Reminders:

- ☐ GPMP Date Completed _ _ / _ _ / _ _ _ _ Item Billed _____
- ☐ MHCP Date Completed _ _ / _ _ / _ _ _ _ Item Billed _____
- ☐ Other Recalls/Reminders, please specify _____

We use Best Practice and would prefer to receive records electronically in XML format. If this is not possible, we would appreciate a **Patient Health Summary via fax ASAP** and the full records can be sent via disc or printed copy as soon as possible.

If you require the patient to pay a fee for the transfer of records, please advise our clinic that you have informed the patient, however please fax a **Patient Health Summary at a minimum** to ensure ongoing care of the patient.

Please contact us with any queries. Thank you for your prompt assistance.

Middle Island Medical Clinic
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