



Shop 2, Murray Street
GAWLER, SA 5118
Phone: (08) 8522 3877
Fax: (08) 8522 3955

This form needs to be completed to request the transfer of a patient's medical records.

Date

To
.....
.....

Dear Doctor,

The Patient/s listed below is/are attending our Practice. We would be grateful if you could forward a copy of their Medical Records/Updated Medical Summaries & Specialist Letters.

Please include copies of any GP Management Plans, Team Care Arrangements, Mental Health Treatment Plans or Home Health Assessments completed within the last 12 months or any relevant information you feel could be of assistance.

Our Practice uses Best Practice Software and is able to accept records on discs that are compatible with our software (XML format).

If a fee is charged for the transfer of any patient information, please contact and advise the patient directly.

Files to be transferred

1. Patient's Name _____ DOB ____/____/____

2. Patient's Name _____ DOB ____/____/____

3. Patient's Name _____ DOB ____/____/____

Signature of the Patient/s

1. _____ 2. _____ 3. _____

Signatures for Patients 16yrs & over

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