19 Lakehead Drive, Sippy Downs, Qld 4556
Tel: 07 5477 0644, Fax: 07 5476 6644

Transfer of Patient Medical Records Form

Our preferred method of transfer is via medical objects.

Dear Doctor:

……

Medical Centre Name and Address: ……

……

Phone/Fax: ……

Re: (Patient Name) ……

Date of Birth: ……

Patient's address: ……

Patient consent

I, _____consent to the release of my medical records and any other relevant clinical information to Ocean Family Medicine.

Patient name: (please print) _____

Signature: _____Date: _____

If not patient signing – name: (please print) _____

Your relationship to patient: (e.g. Mother, Father, guardian, carer) _____

Doctor requesting file: (please circle one) Dr Oliver Gunson □ Dr Emile Brits □ Dr Christine Boeke □ Dr Alison Muller □ Dr Casey Nissen □ Dr Alison Hanks □

It would assist us with this patient's ongoing care if you would be able to provide the following information: □ Health summary □ Health assessment □ Reminders

Item number	Date billed	Item number	Date billed	Item number	Date billed	Item number	Date billed	Item number
721		723		732		2715		2717