HEIDELBERG WEST MEDICAL

I, _____ give consent for my medical records to be released to Heidelberg West Medical, Shop 2/15, 15-23 The Mall (1C), Bell Street, Heidelberg West VIC 3081

Patient Date Of Birth:
_____

Patient Address:
_____

Patient's previous clinic/GP:

_____

Phone: _____

Fax: _____

Patient signature:
_____

Date: _____

Please include the following:

- ☐ Health Summary
- ☐ Health Assessment
- ☐ GP Care Plan (721)
- ☐ Team Care Arrangement (723)
- ☐ Investigation Reports
- ☐ Immunisation History
- ☐ Visit Notes
- ☐ Specialist Letters
- ☐ All Existing Records

I authorise for this release to be:

- ☐ Faxed to the requested practice
- ☐ Sent by mail to the requesting practice

If sending by CD, format must be in XML

_____

OFFICE USE ONLY

Date copy sent: _____

Signature of Practice Representative: _____

TRANSFER OF MEDICAL RECORDS FORM

HEALTH GROUP

Shop 2/15, 15-23 The Mall (1C), Bell Street
Heidelberg West VIC 3081

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