Appin Medical Centre
1/74 Appin Road, Appin NSW 2560
P:02 4488 1090 F:02 4488 1099

Email: info@appinmedical.com.au

Request for Medical Records Transfer

Date: _____

Dear Dr/Surgery Name: _____

Ph: _____ **Fax:** _____

Patient full name (print)	**Address**	**DOB**	**COPY OF ID & MEDICARE ATTACHED**
			YES/NO

Other family members (if under 18 years of age)	**Address**	**DOB**	

The above mentioned now attends this practice. To assist in their future medical management. Would you kindly forward:	
☒ Please do not send original documents ☒ Their clinical records ☒ An accurate health summary, with relevant correspondence and results, ☒ Details of any CDM or PIP Items claimed within the last 2 years. (eg GPMP,GPMHP)	

These records can be forwarded by:	☒ Mail ☒ Fax / Email Encrypted email (PKI) Non rewritable CD.	
Or electronic version format should be:	☐ HTML ☐ XML	

Yours sincerely

My Family Health Admin

Patient Signature:_____

If patient is Under the age of 18 both parents must sign:

Parent Signature 1 : _____

Parent Signature 2: _____