142 Pine Ave Mildura VIC 3500
mildurafamilymc.com.au
T: 03) 5002 9290
F: 03) 5002 9293
E: reception@mildurafamilymc.com.au

MILDURA FAMILY MEDICAL CENTRE

Date:__/__/__

To: _____ Fax No. _____

_____ Phone No. _____

Dear Doctor,

Request for transfer of patient medical records

The patient listed below now attends this practice, please forward a copy of their medical records.

Please send the records electronically in xml format.

Patient (full name): _____

Date of Birth: _____

Address: _____

_____

Additional family members:

Name:_____ Date of Birth:_____

Name:_____ Date of Birth:_____

Name:_____ Date of Birth:_____

Name:_____ Date of Birth:_____

Patient consent

I, _____ consent to the release of my medical records and any other relevant clinical information to **Mildura Family Medical Centre.**

Patient name: (please print) _____

Signature: _____ Date:_____

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

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

Please email or fax the completed form to: reception@mildurafamilymc.com.au