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:___/___/___
Previous Practice: _____ Fax No. _____
Address: _____ 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: _____

_____

Phone: _____

Additional family members to transfer: (each person over 16 years old, will need to sign for themselves)
Name:_____ DOB:_____ Signature: _____
Name:_____ DOB:_____ Signature: _____
Name:_____ DOB:_____ Signature: _____
Name:_____ DOB:_____ Signature: _____
Name:_____ DOB:_____ Signature: _____

Patient consent

I, Patient name: (please print) _____ consent to the release of my medical records and any other relevant clinical information to **Mildura Family Medical Centre.**

Signature: _____ Date:_____

If patient unable to sign – signee 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