Request and Consent - Transfer of Medical Records

Practice: _____

_____

Phone: _____

Fax/Email _____

Dear Doctor,

The patient(s) listed below now attend this practice and has requested that his/her complete health record be forward to us via Medical Objects, to assist with their ongoing care.

PLEASE INCLUDE ANY SPECIFIC HEALTH CONCERNS, REPORTS, PATHOLOGY AND IMAGING

Please fill in due dates, reminders and date last billed for Care Plans and Mental health Plans

Item Number	Date Billed	Item Number	Date Billed	Item Number	Date Billed
965		2700		2715	
967		2701		2717	

Requesting DOCTOR

Dr G. Sharma Dr T. Kenny Dr M. Fitzsimon Dr J. Berggren Dr S. Burgess Dr B. Kanuru Dr J. Harvey

Dr J. Luna

Our preferred method of receiving medical records is Medical Objects

If your practice uses Best Practice software, please send in XML format.

PATIENT CONSENT:

I/We give permission for my/our medical records to be transferred to North Shore Medical Centre as this is the practice I am/we are now attending for medical care.

Patient Name: _____DOB: _____ Minor: Yes ◯ No: ◯

Signature: _____Parent/Guardian: _____

Patient Name: _____DOB: _____ Minor: Yes ◯ No: ◯

Signature: _____Parent/Guardian: _____

Patient Name: _____DOB: _____ Minor: Yes ◯ No: ◯

Signature: _____Parent/Guardian: _____

NORTH SHORE MEDICAL CENTRE (ABN 41906254950)

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Email: reception@nsmedical.com.au