# Request and Consent - Transfer of Medical Records

**Att:** Dr_____

_____

**Phone:** _____

**Fax:** _____

Dear Doctor,

The Patient(s) listed below now attend this practice and as requested that his/her complete health record via **Medical Objects**, to assist with their ongoing care.

**Please Include:**

Specific Health Concern(s): _____

Reports: _____

Pathology/Imaging: _____

**Clinical Reminders & Due Dates:** _____

| Item Number | Date Billed | Item Number | Date Billed | Item Number | Date Billed |
|---|---|---|---|---|---|
| 721/723 | | 2700 | | 2715 | |
| 732 | | 2701 | | 2717 | |

**Requesting Dr:**

Dr G. Sharma  Dr M. Fitzsimon  Dr T. Kenny  Dr S. Burgess  Dr R. McDermott  Dr B. Mason

~~~ Please forward at your earliest convenience via **Medical Objects** or fax (07) 5448 9300) ~~~

**~~~ PLEASE DO NOT SEND CD ~~~**

**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: _____

Patient Name: _____ DOB: _____ Minor: YES / NO

Signature: _____ Parent/Guardian: _____

**NORTH SHORE MEDICAL CENTRE (ABN 41906254950)**
PO Box 9547 Pacific Paradise Q 4564
Phone: 07 5448 9200 Fax: 07 5448 9300
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