



Pear Tree  
Family Practice

## TRANSFER OF MEDICAL RECORDS REQUEST AND AUTHORITY FORM

The below named person(s) has/have been patient(s) of your medical practice. They are now attending Pear Tree Family Practice. We would appreciate your assistance by forwarding their relevant medical history to Pear Tree Family Practice to facilitate their ongoing care.

I \_\_\_\_\_ date of birth \_\_\_/\_\_\_/\_\_\_

I \_\_\_\_\_ date of birth \_\_\_/\_\_\_/\_\_\_

I \_\_\_\_\_ date of birth \_\_\_/\_\_\_/\_\_\_

I \_\_\_\_\_ date of birth \_\_\_/\_\_\_/\_\_\_

I \_\_\_\_\_ date of birth \_\_\_/\_\_\_/\_\_\_

Of \_\_\_\_\_ (address)

Authorise \_\_\_\_\_ (name of practice)

Telephone \_\_\_\_\_

Fax \_\_\_\_\_

To release my full patient health record to

Pear Tree Family Practice

118 Partridge Street

Glenelg South SA 5045

Phone 08 7228 5818 Fax 08 7228 5819

I authorise release of these records by either fax/mail/electronic file

Patient signature \_\_\_\_\_

Date \_\_\_/\_\_\_/\_\_\_

Patient signature \_\_\_\_\_

Date \_\_\_/\_\_\_/\_\_\_

DISCLAIMER: The information contained in the facsimile message is intended for the sole confidential use of the designated recipients and may contain confidential information. If you have received this information in error, any review, dissemination, distribution or copying of this information is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone on 08 7228 5818 and return the original message to us. Thank you.

Pear Tree Family Practice  
118 Partridge Street  
Glenelg South SA 5045  
Phone 08 7228 5818 Fax 08 7228 5819