



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 previous practice)

Telephone _____ Fax _____

To release my full patient health record to

Pear Tree Family Practice
16 Partridge Street
Glenelg 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

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