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 ___/ ___/ _____

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