Appletree Hill Medical Centre

DR JILLIAN GEORGE MBBS
DR MICHAEL DE SOUZA MBBS (Hons) FRACGP DipRACOG
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appletreehill medical centre

TRANSFER OF MEDICAL RECORDS REQUEST FORM

Doctor/Clinic Name ----------

Clinic Address ----------

Phone ---------- **Fax** ----------

- The following patient/s are now attending Appletree Hill Medical Centre. Please forward on a disk a copy of all relevant medical information including copies of significant reports/test results, to facilitate their ongoing treatment. We prefer **XML** format for Medical Director or **HTML** format if using another medical software
- Please provide recent results, discharge summaries and or any correspondence you may have in relation to this patient

PATIENT NAME ---------- **DOB** ----------

PATIENT NAME ---------- **DOB** ----------

PATIENT NAME ---------- **DOB** ----------

PATIENT AUTHORITY
I/We authorize Appletree Hill Medical Centre to receive my/our full medical history.

Signed ---------- **Date** ----------