

Appletree Hill Medical Centre



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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 a copy of all relevant medical information including copies of significant reports/test results, to facilitate their ongoing treatment. We prefer **XML** format emailed to info@applethillmc.com.au. We use Best Practice 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** -----