Beaudesert Family Practice
Beaudesert Fair Shopping Centre
38 William Street, Beaudesert QLD 4285
Ph: 07 5541 3111 **Fax: 075541 3324**

Date: _____

Practice/Hospital Name and Address:

_____

_____

_____

Phone: _____

Fax: _____

Dear Doctor,

Re: Request for transfer of patient medical records

As the patient listed below now attends this practice, please forward a copy of their medical records (or a complete and accurate health summary) and any other relevant clinical information to assist in the continued management of their healthcare.

Patient (full name): _____

Address: _____

Date of Birth: _____

If sending the records electronically, please send them in an **.rtf** format.

Patient consent

I, _____ consent to the release of my medical records and any other relevant clinical information to Beaudesert Family Practice.

Patient name: (please print) _____

Signature: _____ Date: _____

If not patient signing – name: (please print) _____

Your relationship to patient: (e.g. Mother, Father, guardian, carer) _____

Yours sincerely,

Reception on Behalf of Dr _____