

Dr Stephen	NAPOLI	MBBS (Adel)	FRACGP DRCOG (Obst) DCH	Provider 2101538A
Dr Sonia	SCHUTZ	BMBS	FRACGP, FARGP, DCH, DRANZCOG, Grad Dip Rural, Grad Dip Pall Care	Provider 222715BX
Dr Hamoudi	ALDYNI	MBChB	FRACGP	Provider 276888HK
Associates				
Dr Peter	JOYNER	MBBS (Adel)	FACRRM DRCOG (Obst) OAM	Provider 0146045H
Dr Myrtle	STIBBE	BMBS		Provider 0434455JY

CONFIDENTIAL

REQUEST TO TRANSFER MEDICAL RECORDS

Date _____ Fax: _____

TO: _____ Phone: _____

We wish to advise that the patient(s) listed below are now attending our medical centre. To ensure privacy and continuity of care, it is requested that their medical records be transferred to this centre by fax or registered mail. PLEASE DO NOT SEND INFORMATION ON A DISC OR USB.

****We understand that a fee may apply and request that the patient be advised of any fees relating to the copy and transfer of their medical records.****

FULL NAME:	DATE OF BIRTH:	SIGNATURE:
_____	_____	_____
_____	_____	_____
_____	_____	_____

CURRENT ADDRESS:

PREVIOUS ADDRESS:

I – the above named person – give consent for a copy of our medical notes to be released to Mannum Medical.

Would you please send a **COPY ONLY** of the above patient/s Health Summary and a **COPY ONLY** of any relevant, specialist investigations, history of chronic or unusual conditions.

We would also appreciate the PLAN history of the patient as listed below:

EPC Item	Completed Yes/No	Date Completed
GMP Created (item 721)		
TCA Created (item 723)		
Mental Health Plan (item 2700, 2701, 2715, 2717)		

Yours sincerely,

_____ Medical Records Clerk

OFFICE USE

DR _____