

PATIENT REQUEST FOR TRANSFER OF MEDICAL RECORDS

Please arrange for the transfer of medical records as authorised below.

WE ARE A PAPERLESS PRACTICE and require RECORDS SENT via

xml. FORMAT in an email alternatively on a USB or via **Healthlink (berrigan)**

	<i>Date of Last Review</i>
Asthma Review	
Diabetic Annual Cycle of Care	
GPMP (item 721)	
TCA (item 723)	
GPMP/TCA review (item732)	
Mental Health Plan (item 2701/2702)	
45-49year or 75+ Health Assessment	

Patients Name	Date of Birth	Signature (over 16yrs)

Patient Authorisation:

I hereby authorise (Practice name) _____

Phone: _____

Fax: _____

to release copies of my medical records to the following Practice:

Berrigan Family Medical Centre
1/219 Berrigan Drive, JANDAKOT, WA,6164
P: 08 9417 2454
info@berriganfmc.com.au

_____/_____/_____
 Patient/Guardian Signature Date