

Request for Medical Records Transfer

Rochedale Family Practice
 2/48-54 Koobil Street, Rochedale South Qld 4123
 Ph: 07 3341 2022 Fax: 07 3219 0789 Email: reception@rochedalefp.com.au

Date: _____

To Clinic: _____

Attention Dr: _____

Phone No: _____ Fax No: _____

Our Requesting Dr: _____

(When Faxing / Mailing back, please ATTENTION to REQUESTING DOCTOR)

Patient Full Name (print) and Signature	Address	DOB
Name: _____ Signed: _____	_____ P/Code: _____	_____
Other Family Members - Signature Required if over 18	Address	DOB
Name: _____ Signed: _____	_____ P/Code: _____	_____
Name: _____ Signed: _____	_____ P/Code: _____	_____
Name: _____ Signed: _____	_____ P/Code: _____	_____

The above mentioned patient/s is now attending Rochedale Family Practice.
To assist in their future medical management would you kindly forward:

<input type="checkbox"/>	Their clinical records, with relevant correspondence and results
<input type="checkbox"/>	Details of any CDM or PIP Items claimed within the last 2 years. (eg GPMP)
<input type="checkbox"/>	Other: (Details) _____

Please advise the patient directly of any fees that apply to the Transfer of Records.

These records can be forwarded by:	<input type="checkbox"/> Mail <input type="checkbox"/> Medical Objects <input type="checkbox"/> Fax
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Yours sincerely,
Rochedale Family Practice

This facsimile is confidential to the addressee. It may be privileged. Neither of these are waived if this transmission has been received in error. Please advise the sender immediately by phone/fax if you have received this transmission in error then destroy the copy.