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:

- ☐ Their clinical records, with relevant correspondence and results
- ☐ Details of any CDM or PIP Items claimed within the last 2 years. (eg GPMP)
- ☐ Other: (Details) _____

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

These records can be forwarded by:	☐ Mail	☐ Medical Objects	☐ Fax

Yours sincerely,
Rochedale Family Practice