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TRANSFER OF PATIENT RECORDS

Dear Dr. ____________________________of ________________________________

____

Phone : ________________________

Fax : _________________________

The person or persons below are attending our practice now. We would appreciate it very much if you could forward us a complete medical record for continuity of care.

IT IS PREFERRED IF YOU CAN SEND US THE INFORMATION IN A DISC IN XML FORMAT

Patient Name _________________________________ DOB _________________
Patient Name _________________________________ DOB_________________
Patient Name _________________________________ DOB_________________
Patient Name _________________________________ DOB_________________

Patient Address____

____

Patient Authority : I Authorize the release of the above medical record to doctors at the Rockingham GP.

Patient/ Parent/Guardian Signature ______________________________

Attending Doctors Signature ________________________________

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