Shop-12, 250-270 Donnybrook Road, Mickleham VIC 3064
Telex: 03 7035 9132, FAX: 03 7037 3192
Email: info@merrifieldcitymedicalcentre.com.au

Transfer of Medical Records Consent Form

I,…………………………………………………………………………………..give consent for my medical records to be released to Merrifield City Medical Center, 250-270 Donnybrook Road, Mickleham VIC 3064.

(Send by XML format only)

Patient D.O.B: ………………………………………………

Address of Patient:………

……

Patient's previous clinic:……

Phone:……………………………………………………………………Fax:………………………………………………………………………

Patient signature:………………………………………………………. Date:……………………………………………………………….

Family members:

1. Full name: D.O.B: Signature
……………………………………. ………../………../………….. ……………………………………….
2. Full name: D.O.B: Signature
……………………………………. ………../………../………….. ……………………………………….
3. Full name: D.O.B: Signature
……………………………………. ………../………../………….. ……………………………………….
4. Full name: D.O.B: Signature
……………………………………. ………../………../………….. ……………………………………….

Please include the following:

Health summary ☐
GP Care Plan (721) ☐
TCA (723) ☐
Health Assessment ☐

All Existing ☐ Records
Immunisation ☐ history
Specialist ☐ Letters
Investigation ☐ reports

Office Use Only:

Signature of Practice Representative:……………………………………. Date Copy Sent:…………………………………………..