McKinnon Hill Medical Centre

Request for Medical Records Transfer

Dear Dr/Practice:	
Phone:	
Fax:	

Patient Name:	
Address:	
Date of Birth:	

Other family members (under the age of 18):

FULL NAME:	DOB:	GENDER (Male/Female)

☐ An accurate health summary, with relevant correspondence and results,	☐ Details of any CDM or PIP Items claimed within the last 2 years. (eg GPMP)	☐ Other relevant Information

The above patient now attends this practice.
To assist in their future medical management, would you kindly forward their relevant clinical records.
These can be forwarded **electronically, by mail, or fax**. Electronic version format should be **HTML**.

Signed: ……..…..…… **Date:** ……

Submit