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) |
|---|---|---|
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|---|---|---|
| ☐ 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**.
We use Best Practice Medical software. Electronic version format should be **XML**.

**Signed:** ……..…… **Date:** ……

**You will need the latest version of Acrobat Reader to submit this form online.
Alternatively, you may also fill up this form online, download it as a PDF, and email us at **info@mckinnonhillmc.com.au**

**Phone: 03 99997280 | Fax: 03 86726624 | Email: info@mckinnonhillmc.com.au**
**86 McKinnon Road McKinnon Vic 3204 | www.mckinnonhillmc.com.au**

Submit