Inkerman Medical Group

# Patient records transfer authority form

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|---|---|---|---|---|
| Dr Naomi Bronzite<br>Provider No: 438492BJ | Dr Belinda Carne<br>Provider No: 5744932A | Dr Sharon Gabizon<br>Provider No: 432684JF | Dr Debbie Herbst<br>Provider No: 0629358B | Dr Ilana Laser<br>Provider No: 2526666L |
| Dr Leon Massage<br>Provider No: 022697GJ | Dr Tamara Schnall<br>Provider: 422166GW | Dr Anthony Schneeweiss<br>Provider No: 046380CT | Dr Stephen Szental<br>Provider No: 0345821T | |

Dear Doctor,

The below mentioned patient(s) are now attending this practice. Would you kindly forward their complete clinical records to assist in their future management. We use Best Practice software and prefer patient files to be emailed in XML format to reception@inkermanmedical.com.au.

I (full name), _____

of (address) _____

give consent to Dr _____ to request a copy of the entire contents of my medical record.

I understand that the transferring doctor may charge me a reasonable fee in order to complete the transfer.

Signature of Patient: _____ Date of Birth: ____/____/_____

Today's Date: ____/____/_____

**Additional Family Members:**

| | | |
|---|---|---|
| Patient Name: | Date of Birth: | Patient Signature: |
| Patient Name: | Date of Birth: | Patient Signature: |
| Patient Name: | Date of Birth: | Patient Signature: |
| Patient Name: | Date of Birth: | Patient Signature: |

**To Transfer my Patient File from:**

Doctors Name: _____

Clinic Name: _____

Clinic Address: _____

Phone Number: _____

Fax Number: _____

Please return your completed form along with a copy of your photo identification showing your signature e.g. drivers' licence to reception@inkermanmedical.com.au

**All patients aged 16 and over are required to sign.**

290 Inkerman Street, St Kilda East VIC 3183 | T: 03 9527 4355 | F: 03 9525 9033
reception@inkermanmedical.com.au | www.inkermanmedical.com.au