Inkerman Medical Group

PATIENT RECORDS TRANSFER AUTHORITY FORM

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 downloaded onto a disk or USB in .XML format.**

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.

Dr Debbie Herbst
Provider No: 0629358B

Dr Stephen Szental
Provider No: 0345821T

Dr Anthony Schneeweiss
Provider No: 046380CT

Dr Ilana Laser
Provider No: 2526666L

Dr Leon Massage
Provider No: 022697GJ

Dr Tammy Schnall
Provider: 422166GW

Dr Sangeeta Nagpal
Provider No: 2667125T

Dr Sharon Gabizon
Provider No: 432684JF

Dr Naomi Bronzite
Provider No: 438492BJ

Dr Belinda Carne
Provider No: 5744932A