Kelvale Medical Group

Date:

Name of Medical Practice: ____

Phone No: __________________ **Email Address:** ______________________________

Dear Doctor,

Re: Request for transfer of patient medical records

As the patient listed below now attends this practice, please forward a copy of their medical records (or a complete and accurate health summary) and any other relevant clinical information to assist in the continued management of their healthcare.

Patient (full name): ______________________________

Address: ______________________________

Date of Birth: ______________________________

Patient Medical Records are confidential - please transfer all records **electronically** – via **.xml** format on disc **OR** encrypted email **OR** Healthlink ID: **KELVALEW**.

Patient consent

I, ________________________ consent to the release of my medical records and any other relevant clinical information to **Kelvale Medical Group.**

Patient name: (please print) ____

Signature: ____ Date: ___________________________

If not patient signing – name: (please print) ____

Your relationship to patient: (e.g. Mother, Father, guardian, carer) ______________________________

Yours sincerely,

Dr ____

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