TUGGERANONG SQUARE MEDICAL PRACTICE

TRANSFER OF PATIENT RECORDS OUT

I/We hereby request a copy of my/our medical records to be transferred from Tuggeranong Square Medical Practice to the following Doctor/Practice:

To Doctor/Practice:

_____

_____

Address of Doctor/Practice:

_____

_____

Phone Number of Doctor/Practice: _____

Fax Number of Doctor/Practice: _____

AUTHORISATION

I/we hereby authorise the transfer of my/our medical records from Tuggeranong Square Medical Practice to the above Doctor/Practice.

I/we agree to pay the fee of $15.00 per patient in the ACT ($22.00 if sending interstate) for this service BEFORE the file is transferred.

Patient details:

Name: _____DOB:_____Signature:_____

_____

Name: _____DOB:_____Signature:_____

_____

Name: _____DOB:_____Signature:_____

_____

Name: _____DOB:_____Signature:_____

_____

Home Address:

_____

_____

Please attach a copy of photo ID of ALL patients over the age of 16 years.

Phone 02 6175 0400 Fax 02 6293 2970
1/341 Reed Street South, Greenway ACT 2900