



TRANSFER OF MEDICAL RECORDS REQUEST & CONSENT

Dear: Dr _____

Clinic: _____

Ph: _____

Fax or Email: _____

Dear Dr _____,

The patient listed below wishes to transfer their medical records to St James Family Medical & St James Specialist and is requesting that his/ her complete health records are sent to our clinic to assist with their ongoing care.

Please forward records at your earliest convenience. Our medical facility uses Best Practice and records in XML format by email or disk is our preferred method of transfer. Alternatively, please email to info@stjamesfamilymedical.com.au or transfer via Health Link to *stjamesf*

Patient Consent:

I give my permission for my complete health records to be transferred to St James Family Medical & St James Specialist as I will be attending this clinic for ongoing medical care.

Patient Name: _____

Date of Birth: _____

Address: _____

Patient/ Guardian Signature: _____