**Request For Transfer Of Medical Records**

Dr

Practice

Address

Suburb

Ph:

Fax:

Email:

Date: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

Dear Dr \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We wish to advise that the patient(s) listed below is (are) now attending our practice. To ensure continuity of care, please provide an electronic copy of their full medical record at your earliest convenience. The patient/s authority to release this confidential information is provided below.

**If your clinic uses Best Practice, MD, or compatible software, we ask that the notes be received as an XML file. Please export the patient files onto disc, USB, or send them via email at your earliest convenience.** **Please contact the clinic if you are unable to facilitate this request electronically.**

I hereby authorise the release of my medical records to Dr \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, at Integrative Health Solutions. I further authorise that my medical records be:

Sent by USB/disc/mail/fax via Australia post standard mail delivery, courier, or hand delivered.

Sent by unsecured email to [admin@integrativehealthsolutions.com.au](mailto:admin@integrativehealthsolutions.com.au).

|  |  |  |  |
| --- | --- | --- | --- |
| Patients Name: |  | Date of Birth: |  |
| Current Address: | | | Phone: |
| Signature: |  | **Date:** |  |

Please include other members of my family (18 years and under / dependents), as listed below:

|  |  |  |  |
| --- | --- | --- | --- |
| Patients Name: |  | Date of Birth: |  |
| Patients Name: |  | Date of Birth: |  |
| Patients Name: |  | Date of Birth: |  |
| Patients Name: |  | Date of Birth: |  |

Have the following items been billed for the(se) patient(s) in the past 12 months? Please indicate below by circling the relevant item, entering the dates billed and noting the initials of the patient:

|  |  |  |  |
| --- | --- | --- | --- |
| GPMP: | # 721 | Date Billed: | / / |
| TCA: | # 723 | Date Billed: | / / |
| GPMP/TCA Review: | # 732 | Date Billed: | **/ /** |
| >75 Health Assessment: | # 701 / 703 / 705 / 707 | Date Billed: | **/ /** |
| GP Mental Health Plan: | # 2700 / 2701 / 2715 / 2717 | Date Billed: | **/ /** |
| GP Mental Health Plan Review: | # 2712 | Date Billed: | **/ /** |
| Diabetes Annual Asses. | # 2517 / 2521 / 2525 | Date Billed: | **/ /** |

Thank you for your assistance.