Shop 5/9 Marshall Lane
Kenmore, QLD 4069
Phone: 07 3087 5380
Fax: 07 3378 8774

MARSHALL LANE
MEDICAL CENTRE

REQUEST TO TRANSFER MEDICAL RECORDS

Practice name: _____

Ph: _____

Fax: _____

We wish to advise that the patient listed below are now attending our Medical Centre.

To ensure continuity of care, it is requested that their medical records be transferred.

We understand that a fee may apply and request that the patient be advised of any fees relating to the copy and transfer of their medical records.

We would also appreciate the EPC history of the patient as listed below:

EPC Item	Completed YES/NO	Date Completed
GPMP Created (Item 721)		
TCA Created (Item 723)		
GPMP/TCA Review (Item 732)		
Health Assessment (Items 701-707)		
GPMHTP (Item 2715-2717)		
GPMHTP Review (Item 2712)		

Patient Details:

Patient(s) Surname: _____
Address: _____

First Name: _____ **DOB:** ___ / ___ / ____ **Signature:** _____
First Name: _____ **DOB:** ___ / ___ / ____ **Signature:** _____
First Name: _____ **DOB:** ___ / ___ / ____ **Signature:** _____
First Name: _____ **DOB:** ___ / ___ / ____ **Signature:** _____

**Please note that all patients over 16 years of age MUST sign to authorise the transfer of their medical records.*

Health Information Requested:

1. **Pathology results/ providers:** _____
2. **X-Ray results/ providers:** _____
3. **A summary of My Health Record including:**
   - current medications, immunisations and any correspondence on file

Please fax these records at your earliest convenience to 07 3378 8774

Practice Stamp:

IMPORTANT NOTICE: *This fax is confidential and should only be used by the intended addressee. If you were sent this fax by mistake, please inform us by phone or email and then destroy this message.*