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REQUEST FOR MEDICAL RECORDS

(Please supply in paper format only as we are unable to process discs)

To (Doctor's Name): _____

Practice Address: _____

Ph:_____

Fax: _____

Patient's Name: _____

Date of Birth: _____

Current Address: _____

I Request for my records to be transferred, ***in full***, to The Wellness House so that treatment can commence immediately.

I also request for the following family members' records to be transferred to The Wellness House.

Patient's Legal Name:_____ **D.O.B:**_____

Patient's Legal Name:_____ **D.O.B:**_____

Patient's Legal Name:_____ **D.O.B:**_____

I understand that these documents will sent by post/email or fax to The Wellness House._____

Signed:_____ **Date:**_____