CESSNOCK MEDICAL CENTRE

Cessnock Surgery Pty Ltd, trading as Cessnock Medical Centre

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PATIENT TRANSFER REQUEST

Date:............/............./.............

Dear Dr: ....

Address: ....

....

Phone: .... **Fax:** ....

Patient Name:	
DOB:	
Address:	
Gender: (Please tick)	☐ Male ☐ Female

The above named patient has requested a copy of their medical records to be transferred to this practice. Could you please forward any health summaries, clinical notes, specialist reports, pathology, imaging, including a copy of patients last GPMP, that would assist with the ongoing care of the patient. **Please do not send XML files unless you use Medical Director.**
Please send files as a PDF via email, or post paper copies of medical records.

Kind Regards

Dr. Yang Wang / Dr. Erek Malate / Dr. Anne Wakatama

Per:

Patient's Consent:

I, ……...…..

hereby consent to release my medical records to Cessnock Medical Centre.

Signed:..

(If the patient is under 14yrs – parent or guardian must write and sign in their name)

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