IVES
FAMILY
PRACTICE

Date:

Doctor:_____ Phone:_____

Practice Address: _____ Email:_____

_____

Dear Doctor,

Re: Request for transfer of patient medical records

As the patient listed below now attends this practice, please forward a copy of their medical records and any other relevant clinical information to assist in the continued management of their healthcare.

Patient (full name): _____

Address: _____

Date of Birth: _____

If sending the records electronically, please send them in an .xml format.

Patient Consent

I, _____ consent to the release of my medical records and any other relevant clinical information to Ives Family Practice.

Patient name: (please print) _____

Signature: _____ Date: _____

If not patient signing - name: (please print) _____

Your relationship to patient (e.g. Mother, Father, guardian, career) _____

Yours sincerely,

Ives Family Practice

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