Medical Records Transfer Request Form

Dear Doctor / Practice: _____

Address: _____

Fax/Email: _____

The patient/s mentioned below would like to request that their full medical history be electronically exported and sent to :

Email : reception@homesteadmc.com.au

Homestead Medical Centre

Shop 1, 101 Ravenhill Blvd, Roxburgh Park, VIC 3064

Patient Name	DOB	Signature

By signing this form, I _____ authorise you to release confidential health information about me to the doctor / practice mentioned below, who is now responsible for my ongoing care.

Signature: Date:

Please do not send the records via printed copies and fax. We prefer records in xml via email and accept XML in a CD as we are using Best Practice. If you have any troubles with this type or transfer, please contact us.