Medical Record Transfer Request

I, ……..**…….. (Patient's full name)**

Of: **……**

……

……

(Patient's current address)

Date of birth: **……**

Formerly of: **……**

……

(Patient's former medical practice details)

Authorise the release of my/my families' medical records to be forwarded to:

(Please forward any relevant medical information via fax or a copy of the patient's file to the address below)

To

Doctors Name: **……**

Medical Practice **……**

Address: **……**

……

……..

Signed: **……** Date: **……**