**FOREST HILL FAMILY CLINIC**
**249 CANTERBURY ROAD, FOREST HILL VIC 3131**
**Telephone (03) 9875 6222 Facsimile (03) 9894 4867**

# Request for Patient History Transfer

**To**

| | |
|---|---|
| **Doctor/Clinic Name** | |
| **Clinic Address** | |
| **Clinic Fax No** | |
| **Clinic Phone Number** | |

This patient is now attending our clinic and has requested a copy of all relevant medical records, together with any CDM items claimed within the last two years (ie GPMP), including all relevant investigations/specialist details be sent on a disc in **XML format for Medical Director** or **HTML, word or PDF for Best Practice**

| | |
|---|---|
| **Patient Name (1)** | _____D.O.B _____/_____/_____ |
| **Patient Name (2)** | _____D.O.B _____/_____/_____ |
| **Patient Name (3)** | _____D.O.B _____/_____/_____ |
| **Patient Name (4)** | _____D.O.B _____/_____/_____ |
| **Patient Address** | |

**I/We_____ authorise the release of my/our records to Forest Hill Family Clinic.**

| | |
|---|---|
| **Patient Signature** | **_____** |
| **Patient Signature** | **_____** |
| **Patient Signature** | **_____** |
| **Date** | **_____/_____/_____** |