Dear: Dr _____

Clinic Name: _____

Clinic Address: _____

Clinic Phone: _____ Clinic Fax: _____

Clinic Email: _____

Patient Name: _____ Patient D.O.B: _____

Patient Address: _____

I hereby authorize the transfer of my medical history to Dr _____

Signed: _____ Date: _____

Name: _____

This patient is now attending Yackandandah Health Medical Centre.

We would be grateful if you could forward to us a copy of their clinical notes or a summary of them. If you are using Medical Director and have the facility to forward these notes using disk, this would be preferred. Authority to release notes to us is granted by their consent above.

PLEASE DO NOT SEND ORIGINAL RECORDS

Yours sincerely,

Yackandandah Health Medical Centre