



NEAL STREET MEDICAL CLINIC

5 Neal Street, Gisborne, Vic, 3437.

P: (03) 5483 3333 F: (03) 5483 3344

Transfer of Medical Notes

Please fill in this form if you would like your medical records transferred from any other health facility.

(USE BLACK PEN ONLY)

Details of Previous Practice (if known)

Previous Practice: _____

Address: _____

Phone: _____ Fax: _____

The patient below would like to attend Neal Street Medical Clinic.

PREVIOUS CLINIC USE ONLY

To assist in their future medical care, please forward the following:

- **Clinical Records** including current/past medications
- Health summary, with relevant correspondence and results
- **Previous Clinic Details of any GPMP, TCA or MHP. (Please include dates)**

GPMP/TCA _____ GPMP Review _____ MHCP/Review _____

Other _____

These records can be forwarded by: Mail (Not double sided if printed please)

Fax DO NOT FAX IF OVER 30 PAGES

CD (In XML format for Best Practice compatibility)

Please do not send records via Email or Argus

Yours truly,

Doctor (insert name) _____

GP, Neal Street Medical Clinic

Patient Information

Name	
Date of Birth	
Address	

Other Family members Under 16

Name	
Date of Birth	
Address	

Name	
Date of Birth	
Address	

Name	
Date of Birth	
Address	

Patient's Signed Authority

I _____ (Patients full name)

Of _____
(Patients current address)

Formerly of _____
(Patients former address if applicable)

Authorize the release of my/my families' medical records to be forwarded to
Neal Street Medical Clinic.

Signed: _____

Date: _____

The information contained is confidential and may also be the subject of Medical Professional Privilege. If you are not the intended recipient, any use, disclosure or copying of this document is unauthorized. If you have received this document in error, please contact us.