KLEMZIG VILLAGE MEDICAL CLINIC

Klemzig Village Medical Clinic
280 North East Road
Klemzig SA 5087

Tel: (08) 8224 7500
Fax: (08) 8224 7555
admin@klemzigvillagemedical.com.au
www.klemzigvillagemedical.com.au

Date: ……..

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Dear Doctor,

Re: Request for transfer of patient medical records

Patient (full name): _____

Address: _____

Date of Birth: _____

As the patient listed above now attends this practice, please forward a copy of their medical records (or a complete and accurate health summary) and any other relevant clinical information to assist in the continued management of their health including a medication list, CST results, GPMP/TCA and MHCP. Please include other members of family (16 years and under) as listed:

Re: _____ D.O.B _____

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If sending the records electronically, please send them in pdf format.

Patient consent

I, _____ consent to the release of my medical records and any other relevant clinical information to **Klemzig Village Medical Clinic**

Patient name: (please print) _____

Signature: _____ Date: _____

If not patient signing – name: (please print) _____

Your relationship to patient: (e.g. Mother, Father, guardian, carer)_____

Yours sincerely,

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