



**Brickworks  
Medical Centre**

**Brickworks Medical Centre**

Ph. (08) 7160 1187 Fax: (08) 7160 1189

**Request for Medical Records Transfer**

Previous Doctor's name.....

Previous Clinic name & address.....

..... Ph .....

Date:.....

Dear Dr.....

RE:.....(Patient Full Name)

.....(Patient Address)

..... (Date of birth)

The above mentioned is now attending this practice. Would you kindly forward their clinical records or an accurate health summary, with relevant correspondence and results, to assist in the future management of this patient. These records can be forwarded by mail or fax. The patients signed authority appears below.

Yours sincerely

Brickworks Medical Centre

**PATIENT AUTHORITY**

I ..... of.....

.....(Address) ..... (DOB)

Request that my health summary/patient record be forwarded to **Brickworks Medical Centre, Shop 39, Brickworks Marketplace, 2 Ashwin Parade, Torrensville SA 5031.**

Signed: ..... Date: .....

**Office Use Only:**

Date Record/Summary Sent: \_\_\_\_\_

Staff Dispatching Information: \_\_\_\_\_

Make a copy of the medical record and the patients' signed request letter/form and dispatch the copy to the new Practice, retaining the original on site for a minimum of 7 years. Note on the first page of the medical record that the patient has transferred and name the new Practice and address. The copy of the patient's medical record is to be dispatched via priority mail check that the new address is authentic.