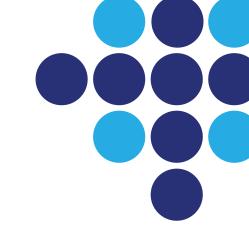
TRANSFER OF MEDICAL RECORDS FORM

LAKES BOULEVARD MEDICAL



l,		give consent
for my medical records to be released to Lake 547 The Lakes Boulevard, South Morang VIC		evard Medical,
Patient Date Of Birth:		
Patient Address:		
Patient's previous clinic/GP:		
Phone:	_	
Fax:	=	
Patient signature:		
Date:		
Please include the following:		
Health Summary Health Assessment GP Care Plan (721) Team Care Arrangement (723) Investigation Reports		Immunisation History Visit Notes Specialist Letters All Existing Records
I authorise for this release to be:		
Faxed to the requested practice Sent by mail to the requesting practice		
If sending by CD, format must be in XML		

OFFICE USE ONLY

Date copy sent: _

Signature of Practice Representative: _

