Albany Clinic

698 Albany Creek Road
Albany Creek, 4305
Tel: 07 3264 2622
Fax: 07 3264 2092

TRANSFER REQUEST FOR PATIENT MEDICAL RECORDS - ADULT

Date: _____

To: _____

_____

_____

Email/Fax: _____

Patient Name: _____ D.O.B: _____

The above-mentioned patient is now attending this practice and is under the care of:

Dr _____

Can you please forward all relevant records for this patient to enable us to provide continued care. To help us access pathology and radiology reports, please provide the name of the provider(s) your clinic utilises.

Could you please forward the records via:

- Medical Objects (preferred)
- Email – reception@albanyclinic.com.au
- Fax – (07) 3264 2092

Could you please advise if the following have been performed at your surgery. If so, we request that a copy of the plans be provided along with the patient records.

GP Management Plan (721)	Date: ____/____/____
Team Care Arrangement (723)	Date: ____/____/____
Mental Health Care Plan (2710 / 2715)	Date: ____/____/____
Health Assessment: (701 / 703 / 705 / 707)	Date: ____/____/____
ATSI Health Assessment (715)	Date: ____/____/____

I hereby authorise the transfer of my medical records, or a summary of my health information, to the doctor / practitioner listed above.

Patient Signature _____ **Date**